St. Louis Metropolitan Medical Society
1023 Executive Parkway, Suite 16 ● Saint Louis, MO 63141
(314) 786-5473 ● www.slmms.org

APPLICATION FOR MEMBERSHIP

_____ Male ❑ Female ❑
LAST NAME FIRST MIDDLE

_____
OFFICE ADDRESS - STREET CITY/STATE ZIP PHONE NUMBER FAX NUMBER

_____
HOME ADDRESS - STREET CITY/STATE ZIP PHONE NUMBER

For mailing please use: ❑ office address ❑ home address E-Mail address _____

Birth _____ Spouse _____
DATE PLACE

Medical Education _____
SCHOOL NAME LOCATION

_____
DEGREE FROM: MO/YR. TO: MO/YR

Place and Type of Service and/or Training

Internship: _____
PLACE FROM: MO/YR TO: MO/YR

Residency: _____
PLACE FROM: MO/YR TO: MO/YR

Fellowship: _____
PLACE FROM: MO/YR TO: MO/YR

Missouri License: _____ Other: _____

Active Hospital Appointments: (1) _____
(2) _____ (3) _____
(4) _____ (5) _____

Teaching Appointments (list dates): _____

Medical Specialty: _____ Date Certified: _____
Subspecialty: _____ Date Certified: _____

Type of Practice: (Check appropriately)
Office Based: Solo ❑ Hospital Based ❑ Government ❑ HMO ❑
Office Based: Group ❑ Teaching/Research ❑ Other (Specify) ❑ _____

Are you a current AMA member: ❑ Yes ❑ No
Are you a current MSMA member: ❑ Yes ❑ No

Specialty Society Memberships: _____

(COMPLETE REVERSE SIDE)

Within the last 5 years, have you been convicted of a felony crime? ❑ Yes ❑ No
If yes, please provide full information.

Within the last 5 years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked? ❑ Yes ❑ No
If yes, please provide full information.

Within the last 5 years, have you been the subject of any disciplinary action by any medical society or hospital staff? ❑ Yes ❑ No
If yes, please provide full information.

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the St. Louis Metropolitan Medical Society, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

_____
APPLICANT'S SIGNATURE

_____
PLEASE PRINT NAME

_____
DATE

_____
Name of SLMMS member to contact as sponsor (optional)

MEMBERSHIP DUES – SLMMS	
STUDENT	
Student enrolled in accredited medical school	Free
RESIDENT/FELLOW	
Physician in a training program - Internship, Residency, or Fellowship	Free
ACTIVE	
First year in practice following training program	$175
Second year in practice following training program and thereafter	[1]$370
[1]Includes an optional $20 gift to the St. Louis Society for Medical and Scientific Education (SLSMSE)	

Make *ONE* check payable to: *St. Louis Metropolitan Medical Society* OR pay by credit card.

First–year full SLMMS membership dues are prorated as follows (active members only) for applications received:	
January – June; October – December[3]	[2]$370
July – September	[2]$195
[2]Includes an optional $20 gift to SLSMSE [3]Oct.-Dec. dues collected applied to following year	

Mail to:
St. Louis Metropolitan Medical Society
1023 Executive Parkway, Suite 16
St. Louis, MO 63141

Charge your dues payment to your
☐ MasterCard ☐ Visa ☐ AMEX ☐ Discover
Account Number

— — — — — — — — — — — — — — — —

Expiration Date_____

Amount of Dues$_____

_____
Signature required

_____
Print Name