APPLICATION FOR MEMBERSHIP
NORTH DAKOTA MEDICAL ASSOCIATION
District Medical Society

☐ Active ☐ Resident ☐ Retired

Name_____ Degree_____ Gender_____
Last, First, Middle initial (MD, DO, etc.) (M or F)

Clinic/Office_____

Office Address_____ City_____ State_____ Zip_____

Phone_____ Fax_____ Starting date at clinic/office_____

Office e-mail_____ Personal e-mail_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Home Fax_____

Cell Phone_____

Birth date____/____/____ Birthplace_____

Spouse_____
(First and Last Name)

Medical School_____
(Name and Location)

Medical School Graduation Date_____ ND License Number_____

Residencies_____ Dates_____

_____ Dates_____

Fellowships_____

Specialty_____ Subspecialty_____ Subspecialty_____

Board Certified by_____ Year Certified_____

Board Certified by_____ Year Certified_____

Specialty Society memberships_____

Mail this application to:

NDMA
1622 E Interstate Ave Bismarck,
ND 58503-0512
or email to:staff@ndmed.com

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 Constitutions and By-Laws of the District Society, the North Dakota Medical Association and the American Medical Association.

I hereby release, and hold harmless from any liability or loss, the _____District Medical Society, and the North Dakota Medical Association, 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 to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

_____ ___/___/___
Signature Date

Please attach a photo or send photo electronically to staff@ndmed.com