Vermont Medical Society

Application for Membership

Complete and return with appropriate membership fees to:
*Vermont Medical Society * PO Box 1457 * Montpelier, Vermont 05601*

I. BIOGRAPHICAL DATA

1. Name_____

   Office
   Address_____

   Office Phone_____Office Fax_____

   Email
   Address_____

   Home
   Address_____

   Home Phone_____ Cell or Pager _____

2. Preferred Method of Contact: ☐ Email ☐ Mail

3. For Mail or Roster Use: ☐ Office Address ☐ Home Address

4. Membership Type *(see attached)*: ☐ Active ☐ Associate ☐ Affiliate

5. Born on the_____day of_____19_____

6. Are you licensed to practice Medicine in the State of Vermont? ☐ Yes ☐ No

7. Graduated Medical school in_____

8. Primary Specialty_____Sub Specialty_____

9. If currently associated with Group or Clinic, state name of Organization:
   _____

Applicant Signature_____**Date**_____