DeKalb Medical Society
PROMOTING & PROTECTING THE PRACTICE OF MEDICINE

Please complete the information below to apply for membership to the DeKalb Medical Society.

PERSONAL DATA

Name_____Spouse's Name_____
(First Middle Last Degree) (First Last Degree)

Sex_____ Date of Birth_____/_____/_____(required) County _____

Practice Name_____Office Manager _____

Business Address_____City_____State_____Zip_____

Business Phone_____Business Fax_____Business Email_____

(By providing fax numbers and email addresses, you authorize DMS to use these methods of correspondence)

Home Address_____City_____State_____Zip_____

Home Phone_____Home Fax_____Home Email_____

Preferred Mailing Address: ☐ Business ☐ Home

Education

Primary Specialty _____

Board Certifications _____

Medical School _____ Location _____

Degree _____ Dates _____

Internship _____ Dates _____

Residencies _____Dates _____

_____Dates_____

PAYMENT INFORMATION

$175 – Annual Dues

Payment Method: ☐ Check (made payable to the DeKalb Medical Society)
☐ Credit Card (check one) __ Visa __ MC __ AMEX

Name (as it appears on card): _____

Number: _____Expiration Date: ____/____

Signature: _____

Please mail or fax membership application to:

DeKalb Medical Society
2152 Tanglewood Road
Decatur, GA 30033
(Tel) 770-271-0453 (Fax) 770-271-0634
www.dekmedsoc.org