

**KANSAS CITY SOUTHWEST CLINICAL SOCIETY**  
**PHYSICIAN ASSISTANT & NURSE PRACTITIONER**  
**MEMBERSHIP APPLICATION**

NAME: \_\_\_\_\_

DEGREE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
Street & Office Number City State Zip Code

OFFICE TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-Mail: \_\_\_\_\_

GRADUATE OF: \_\_\_\_\_

LICENSED TO PRACTICE BY STATE BOARD OF HEALING ARTS IN THE STATE(S) OF:  
\_\_\_\_\_ License Number: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

MEMBERSHIP DUES: \$175.00

**PAYMENT INFORMATION**

Check Enclosed  Please charge my credit card

Visa  MasterCard  Discover

Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

V-Code (last 3 digits on signature line) \_\_\_\_\_

***Please return completed form by fax or mail to:***

Kansas City Southwest Clinical Society  
9229 Ward Parkway, Ste. 280  
Kansas City, MO 64114  
Fax: 816/523-3393