

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: \$150.00

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