

Membership Application

Please complete and print the following form and return to us by mail or fax.

Name Degree Specialty

Address

City

State

Zip

Office Telephone Fax E-Mail

Graduate of (Name Medical or Osteopathic College)

Year Residency Completed

Licensed to practice medicine and surgery by state board of healing arts in the following states:

Primary Hospitals Birth Date

Signature _____

Membership Dues - \$ 205/year

Check enclosed Please charge my credit card

Visa Mastercard

Card Number - - - Exp Date /

V-Code (last three digits on signature line)

Please return completed form by fax or mail to:

Kansas City Southwest Clinical Society
9225 Ward Parkway, Ste. 114
Kansas City, Missouri 64114
Fax (816) 523-3393