MEDICAL SOCIETY
OF METROPOLITAN PORTLAND

MEMBERSHIP APPLICATION

NAME:	CELL NUMBER:
CLINIC NAME:	E-MAIL ADDRESS:
CLINIC ADDRESS:	
HOME ADDRESS:	
SPECIALTY:	BOARD CERTIFIED: ☐ Yes ☐ No Date:
Send correspondence to: ☐ Clinic ☐ Home ☐ E-mail:	

MEMBERSHIP LEVELS

(please select your appropriate membership level below):

☐ **Active Member**: $330
Physicians who work full time

☐ **Associate Member**: $200
Physicians who are full-time employees of any governmental agency or who are engaged in full-time scientific work

☐ **Limited Time Practice Member**: $120
Physicians who practice medicine on a compensated basis 20 or fewer hours per week

☐ **Physician Assistant Member**: $100

☐ **Nurse Practitioner Member**: $330

☐ **Inactive Member**: $65
Not currently practicing medicine, but not retired

☐ **Retired Member**: $65
Fully retired from the practice of medicine

☐ **Practice Manager**: $50
Manager, medical practice manager, physician practice manager, administrator, practice administrator, executive director, office manager, CEO, COO, director, division manager, department manager, or any combination some exceptions, people who manage physician practices or a combination of the responsibilities listed here.

PAY BY CHECK:

MSMP
1221 SW Yamhill Street, #410
Portland, OR 97205

PAY BY CREDIT CARD:

CARD NUMBER:	
NAME ON CARD:	
EXPIRATION:	SECURITY CODE:
AMOUNT:	
SIGNATURE:	

I would also like to make a tax-deductible donation to the **PHYSICIAN WELLNESS PROGRAM**: $ _____

☐ Check enclosed ☐ Charge credit card

*All applicants must reside or have a portion of their practice in Multnomah, Clackamas or Washington Counties

I HEREBY APPLY FOR MEMBERSHIP WITH MEDICAL SOCIETY OF METROPOLITAN PORTLAND.

SIGNATURE DATE OF APPLICATION