MEMBERSHIP REINSTATEMENT

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
Values. Ethics. Advocacy.

☐ YES! I was a previous member of the SDSMA and would like to have my SDSMA membership reinstated!

Physician Full Name:____

Office/Clinic Name:________________________________

Office/Clinic Address:______________________________

City:____

State:________________________Zip Code:____________

Office/Clinic Email:_________________________________

National Provider Identifier (NPI) Number ______________

Home Address:_____________________________________

City: ____

State:________________Zip Code: ___________________

Home/Cell Phone:___________________________________

Home Email:_______________________________________

South Dakota License Number:________________________

REQUIRED MEMBERSHIP DUES

SDSMA Active Membership	$490
District Membership (Locate amount on page 2 – enter in box on right)	$__________
TOTAL DUE	**$__________**

☐ Enclosed is my check made payable to SDSMA.

☐ Please bill my credit card.

VISA ☐ MasterCard ☐ Discover ☐

Signature: ____

Credit Card Number:__________________________

Expiration Date:______________________________

Security (V) Code: ___________________________

Cardholder Name: ____________________________

AFFIRMATION AND SIGNATURE

By the applicant's signature below, the applicant authorizes the agency or instrumentality of any state with licensure authority over physicians to verify the applicant's licensure (past or present) and standing with the licensing entity.

The applicant hereby verifies and confirms that the information provided above is true, accurate and complete.

I hereby make application for membership in your Association and, I agree to support its Bylaws, and to conduct myself professionally according to the principles of medical ethics of the South Dakota State Medical Association.

____ ____

Applicant Signature Date of Signature

- Applicable dues, paid in full, must be submitted with this reinstatement application.

❖ **Return this completed reinstatement form and the appropriate membership dues to:**

South Dakota State Medical Association * 2600 W 49th Street, Ste 200 * Sioux Falls, SD 57105
605.336.1965 * Fax: 605.274.3274 * membership@sdsma.org * sdsma.org

DISTRICT MEMBERSHIP

District Medical Societies (DMS). DMS membership is determined geographically, generally by where the physician lives, and dues amounts vary. The DMS provides additional services for members. A map is provided below to assist you in determining the DMS to which you will belong.

Insert the amount from the dues chart below into the Membership Dues chart on page 1 to compute your total dues amount.

District 1: $65	District 4: $50	District 7: $85	District 10: $0
District 2: $125	District 5: $0	District 8: $25	District 11: $0
District 3: $75	District 6: $100	District 9: $75	District 12: $0