SOUTH DAKOTA STATE MEDICAL ASSOCIATION
*Values. Ethics. Advocacy.*

# RESIDENT MEMBERSHIP APPLICATION

Thank you for your interest in joining the South Dakota State Medical Association. Please complete the entire application for consideration as a member in this Association.

## APPLICANT INFORMATION

First Name:_____ Middle Name: _____ Last Name:_____

Date of Birth: _____ Gender: Female ☐ Male ☐

Home Address:_____ Clinic/Office Address:_____

City: _____ City:_____

State:_____ Zip Code: _____ State:_____ Zip Code:_____

Cell Phone:_____ Clinic/Office Phone:_____

Email:_____ Clinic/Office Email:_____

Maiden Name (if applicable):_____ Spouse:_____

Preferred Mailing Address: Home ☐ Office ☐ Preferred Email Address: Home ☐ Office ☐

## EDUCATION AND LICENSURE

### Medical Education

Medical School Name:_____ Location:_____

Degree Received: _____ Date of Completion:_____

### Residencies

Medical Facility:_____ Location:_____

Medical Facility:_____ Location:_____

### Fellowships

Medical Facility:_____ Location:_____

Medical Facility:_____ Location:_____

### Licenses

State:_____ Number:_____ Date:_____

State:_____ Number:_____ Date:_____

Have you been subject to proceedings by a licensing agency to deny, cancel, limit, suspend or revoke a medical license? Yes ☐ No ☐

National Provider Identifier (NPI) Number_____

### Previous Medical or Specialty Societies

Society Name:_____ Dates of Membership:_____

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Have you been subject to disciplinary action by a medical society or hospital medical staff? Yes ☐ No ☐

*Please complete additional information on and sign next page to finalize your application.*

## MEMBERSHIP

Residents are eligible to be Associate Members of the South Dakota State Medical Association. SDSMA membership dues of $20 per year are paid by the residency program. As a member of SDSMA, residents receive mailings from the SDSMA Office, are represented on the SDSMA Council of Physicians, and are eligible and encouraged to participate in all member benefits. This application must be submitted to SDSMA by a residency program in South Dakota, or be accompanied by proof of enrollment in a residency program.

## AFFIRMATION AND SIGNATURE

I certify that I am a resident in good standing at the residency program listed in this application. The applicant hereby verifies and confirms that the information provided above (and, as applicable, attached hereto) is true, accurate and complete, and that the applicant qualifies for the class of membership for which the applicant has applied. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial of my application for membership or revocation of my membership.

I authorize the Sanford Residency Program of the University of South Dakota to provide my current mailing address and enrollment status to the South Dakota State Medical Association (SDSMA) for as long as I am enrolled in the program.

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. For applicants for Associate membership, the applicant authorizes the applicant's residency program or school of medicine to verify the applicant's enrollment. All applicants, as applicable, authorize their District Medical Society to verify their standing and status of their dues.

I hereby make application for membership in your Association, and if accepted as a member, 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

## RETURN INFORMATION

Questions regarding this application should be directed to:
South Dakota State Medical Association
605.336.1965 * Fax: 605.274.3274 * membership@sdsma.org * www.sdsma.org

**Return completed application to:**
**Residency Program Director at your respective location.**