

Application For Membership: Kansas City Gynecological Society

Name		Date of Birth:	
Medical Degree, From		Date of Graduation:	
Internship Date, From:		To:	
Residency Date, From:		To:	
Fellowship Date, From:		To:	
Member of the American Board of Obstetricians and Gynecologists?		Yes	No
If yes, give date you passed the Board:			
If no, are you Board eligible?		Yes	No
Licensed to practice medicine in the following states:			
Do you limit practice to obstetrics and gynecology?		Yes	No
ACOG Membership #			
Have you ever presented a paper before this Society? If so, give date and the name of presentation:		Yes	No
Please list other medical organizations to which you belong:			
Current hospital affiliations:			
List two active members of the Society who will submit a letter of recommendation to the Secretary. (Note: Your application for membership cannot be considered until these letters of recommendation are received)			
1.			
2.			
Primary Office Address:			
City	State	Zip	
Phone:	Fax	Email Address	
Name of Group:			

Return to: Kansas City Gynecological Society
9229 Ward Parkway, Suite 280
Kansas City, MO 64114

816.523.3383 Phone 816.523.3393 Fax Email: info@kcgyn.org Website: www.kcgyn.org