Pennsylvania Neurological Society

Application for Membership

Full Name _____

(Last First Middle) MD / DO

Office/Clinic Name _____

Office Address _____

_____

City, State _____ Zip _____

Phone _____Fax _____Email_____

Please place an "X" here: ____ if you would prefer not to have your name and office information available online.

Residence Address _____

City, State _____Zip _____

Home phone _____ Cell phone: _____

Gender ____ Date of Birth _____ Birth place_____

Medical School (include location) _____

Dates _____

Internship _____ Dates _____

Residency _____ Dates _____

Pennsylvania State License Number _____

Date Issued _____

Professional Memberships:

Preferred Method to receive correspondence: ( ) email ( ) fax ( ) postal service

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( ) Credit Card or ( ) $50 check payable to "Pennsylvania Neurological Society"

If credit card: ( ) MasterCard ( ) Visa

Card Number: _____ Expiration Date: _____

I hereby apply for membership in the PNS, submitted my $50 dues (residents/fellows free), and agree to abide by its Bylaws and the Principles of Medical Ethics. In consideration of the PNS processing my application for membership, I grant permission and consent for their obtaining verification of the above information.

Signature: _____ **Date:** _____

Send application (and check if applicable) to: Attn: Jackie DeWitt, Pennsylvania Neurological Society, Central Medical Arts Bldg., 433 Frye Farm Road, Greensburg, Pennsylvania 15601.
Questions: Contact Jackie Dewitt: (724) 537-0885 x119, or fax (724) 805-0084.