Physician Assistant Application for Membership

North Carolina/County Medical Societies

Online

Full Name (no initials) ☐ PA ☐ PA-C	Today's Date	NC Medical License Number	County Society Name

Practice Name	Date of Birth	Sex ☐ Male ☐ Female	Spouse's name

Business Address (preferred address? ☐ Yes ☐ No)	City, State, Zip	Business Telephone

Home Address (preferred address? ☐ Yes ☐ No)	City, State, Zip	Home Telephone

Preferred E-mail	Business Fax	Send Publications to: ☐ Preferred E-mail ☐ Secondary E-mail ☐ Business Fax ☐ Home Fax
Secondary E-mail	Home Fax	

Current Supervising Physician	PA School (Current Name of School)	Graduation Date	Other Languages Spoken

If elected to membership, and upon payment of annual dues, I agree without reservation to be governed by the Constitution and Bylaws of the North Carolina Medical Society. (Copy may be obtained from the NCMS, PO Box 27167, Raleigh, NC 27611 or call 1-800-722-1350.)

_____ _____

Signature of applicant **Date**

For office use only:
This applicant was elected to membership on

_____.

_____

County Medical Society Secretary/Executive

I am a member of the North Carolina Medical Society and I hereby sponsor the above named individual for Physician Assistant Membership in the NCMS.

_____ _____

Name **Date**

NC Medical Society Dues for Physician Assistants

☐ Full Year…… $147 ☐ Half Year (Joining after July 1)…… $74

County Medical Societies with Physician Assistant Membership Levels

Beaufort-Hyde-Martin-Washington-Tyrell	$150	Gaston……	$100	Richmond……	$100
Brunswick……	$25	Henderson……	$50	Sampson……	$70
Cabarrus……	$225	Iredell……	$55	Wake……	$130
Caldwell……	$75	Johnston……	$45	Watauga……	$25
Cleveland……	$90	New Hanover-Pender……	$247.50	Wilson……	$125
Durham-Orange……	$120	Pitt……	$60		

Please note: County membership is not a prerequisite for joining the NCMS; however, we urge membership in all levels of the federation of medicine.

TOTAL: _____ ☐ Enclosed is a check payable to the NCMS. ☐ Please charge my ☐ Visa ☐ MasterCard.

Account number: _____ - _____ - _____ - _____ Exp. Date: ____/____

3-Digit Security Code (on the reverse of the card): _____

_____ _____

Signature of Cardholder Date

Please return this form to **North Carolina Medical Society, PO Box 27167, Raleigh, NC 27611 or fax to (919) 833-2023.**
Please call the NCMS at 1-800-722-1350 if you have any questions.