

**La Plata Medical Society - Application for Membership**  
Durango, Colorado

DIRECTIONS: Please complete the appropriate parts of this application. A check for the application fee must accompany the application. Make checks **payable** to the La Plata Medical Society. **Send Application and check to: La Plata Medical Society, 316 Sawyer Drive, Durango CO 81303**

\_\_\_\_\_ Active Member \$ 150      \_\_\_\_\_ Retired Member \$ 75      \_\_\_\_\_ Mid-Level Provider \$ 75

**Name** \_\_\_\_\_  
(Last)    (First)    (Initial)    (Degree)    (M/F)

Name of practice or anticipated local practice affiliation: \_\_\_\_\_

**Address** \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ E-mail \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

**Type of Practice:** \_\_\_\_\_ Same Specialty Group \_\_\_\_\_ Multi-specialty group \_\_\_\_\_ Faculty  
\_\_\_\_\_ Administrative \_\_\_\_\_ Retired \_\_\_\_\_ Other (specify) \_\_\_\_\_

**Home** \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Spouse Name (optional) \_\_\_\_\_  
Phone: \_\_\_\_\_ E-mail \_\_\_\_\_

**I prefer to be notified of meetings by:**  office E-mail  office phone  office fax,  home E-mail,  
 home phone,  home fax/other \_\_\_\_\_,  direct mail

Colorado License: \_\_\_\_\_ Other State License(s): \_\_\_\_\_  
(Date Issued / Number)    (Date / Number / State)

Specialty: \_\_\_\_\_ Board Certification(s): \_\_\_\_\_  
Certification # \_\_\_\_\_ Original Date of Certification(s): \_\_\_\_\_ Expiration: \_\_\_\_\_

**Hospital Medical Staff Privileges**

Animas Surgery Center  Mercy Regional Medical Center  Southwest Memorial Hospital  
 Other \_\_\_\_\_  
(Name)    (Address)    (City / State / Zip)

**Practice History** (Include teaching appointments, military, public health service and private practice)

_____ (Location)	_____ (Specialty/Branch of Service)	_____ (Began Mo/Yr. – Ended Mo/Yr.)
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**Medical School / Training Program**

\_\_\_\_\_  
(Full name of institution / City/ State)    (Began Mo/Yr. – Ended Mo/Yr.)

**Residency**

\_\_\_\_\_  
(Full name of institution / City/ State)    (Began Mo/Yr. – Ended Mo/Yr.)

**Reviewed by** \_\_\_\_\_ **Date Approved** \_\_\_\_\_  
 Application Fee Received \$ \_\_\_\_\_, Ck # \_\_\_\_\_  date forwarded to Treasurer \_\_\_\_\_ by \_\_\_\_\_  
 Waived  Other \_\_\_\_\_