



# *Yes!* I would like to join the **Wyoming Medical Society.**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ MD/DO: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Office Manager: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Practice Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

*I prefer to be contacted by:*    Mail     Phone     Fax     Email     At: Home     Office

Medical Education: \_\_\_\_\_ ME#: \_\_\_\_\_

Wyoming License Number and Date Obtained: \_\_\_\_\_

Please list the names of two physicians as references:

\_\_\_\_\_

\_\_\_\_\_

**Please Return to:**

Wyoming Medical Society P.O. Box 4009 Cheyenne, WY 82003  
Phone: 307-635-2424 Fax: 307-632-1973 E-mail: [info@wyomed.org](mailto:info@wyomed.org)