623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
www.kammco.com

Physicians & Surgeons Application for Claims-Made Professional Liability Insurance New Business

Effective January 1, 2022

Application Instructions & Required Information

- Answer all questions completely and accurately.
- Complete this form electronically or print your responses legibly.
- If space is insufficient to answer any question fully, use the **Comments Section** at the end of this application or attach separate documentation.
- Sign and date the application where indicated.
- Provide claim information for the last five years, and include current company loss runs.
- All forms and applications are available online under the Insurance tab of the KAMMCO website.
- If Corporate Coverage is desired, complete the **Corporate Health Care Application**.
- This application is subject to review and acceptance by the company and does not bind coverage. Additional information may be requested.
- Incomplete submissions or lack of required information may delay the underwriting process.

Requested Effective Date (MM/DD/YYYY): _____

A. Applicant Information

Agency Name (if applicable):

Applicant's Name (First, Middle, Last):

Date of Birth (MM/DD/YYYY):	**Social Security Number:**

Designation: ☐ MD ☐ DO ☐ Other (specify below) Specify Other:	**Gender:** ☐ Male ☐ Female

Applicant's Business Address

Street:	City:	State:	Zip:
County:	Business Name:		
Phone:	Fax:	Email:	

Applicant's Home Information (P.O. Box not accepted)

Street:	City:	State:	Zip:
County:	Home Phone:	Mobile Phone:	

Applicant's Billing/Mailing Information

☐ Home ☐ Business ☐ Other (specify):

Street:	City:	State:	Zip:

Business Manager / Contact Person Information

Name:	Title:

Phone:	Fax:	Email:

Type of Practice: ☐ Individual ☐ Employee ☐ Owner/Partner ☐ Other (specify):

Are you a member of the Kansas Medical Society (KMS)? ☐ Yes ☐ No

If no, and you are a Kansas physician, complete the attached KMS membership application.

NOTE: *If you are a Kansas physician, membership in good standing in KMS is required for coverage with KAMMCO.*

B. Current & Previous Coverage

1. Name of current or previous professional liability carrier:

2. Date of current or previous professional liability insurance policy expired, or will expire:

3. Will you continue to carry insurance with another carrier? ☐ Yes ☐ No

   If yes, please explain: _____

4. What type of policy do/did you have? ☐ Claims-Made ☐ Occurrence

   Requested Retroactive Date (MM/DD/YYYY): _____

   Policy Limits: _____

5. Did you purchase/receive a reporting endorsement (tail coverage)? ☐ Yes ☐ No

C. Requested Coverage

Kansas Providers

1. Limits of Liability (Limits are expressed as per claim and annual aggregate.)
   ☐ $500,000 / $1,500,000

2. Indicate Health Care Stabilization Fund (HCSF) Limits
   ☐ $500,000 / $1,500,000
   NOTE: Applicant must complete the HCSF **Notice of Basic Coverage** form.

C. Requested Coverage (continued)

Missouri Providers

1. Limits of Liability (Limits are expressed as per claim and annual aggregate.)
   ☐ $1,000,000 / $3,000,000

2. Are you requesting **Prior Acts Coverage**? *(See note below.)* ☐ Yes ☐ No
   If no, skip to **Section D**.
   If yes, what is the Retroactive Date (MM/DD/YYYY): _____

3. During the period for which you are requesting **Prior Acts Coverage**, was your practice different in any way from your current practice (e.g., different states, procedures, coverages, etc.)? ☐ Yes ☐ No
   If yes, describe the changes in your practice, including all applicable dates in the space provided in the **Comments Section** at the end of this application.)?

NOTE: **Prior Acts Coverage** is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by KAMMCO that your request for Prior Acts Coverage has been approved.

D. Practice Information

1. If you are an independent contractor, list each entity with which you have contracted health care services:

   _____

2. List each professional corporation, limited liability company, or partnership in which you have ownership and for which you are requesting coverage.
   NOTE: You must complete one **Corporate Health Care Application** for each organization listed.

Name	Description of Interest	% of Practice

3. If you, as an individual, employ or contract physician(s) or surgeon(s), complete the following:

Type of Medical Professional	How Many?	Designation	Current Insurer
Physician / Surgeon Assistants		☐ Employee ☐ Contractor	
Nurse Anesthetists		☐ Employee ☐ Contractor	
Nurse Midwives		☐ Employee ☐ Contractor	
Nurse Practitioners		☐ Employee ☐ Contractor	
Technicians (laboratory, medical, x-ray)		☐ Employee ☐ Contractor	
Podiatrists		☐ Employee ☐ Contractor	
Chiropractors		☐ Employee ☐ Contractor	
RNs / LPNs / LVNs		☐ Employee ☐ Contractor	
Other (specify):		☐ Employee ☐ Contractor	

4. If you, as an individual, employ or contract physician(s) or surgeon(s), complete the following:

Employee or Contractor Name	Specialty	Insurer

E. Education, Training, & Work Experience

1. Medical School Information

School of Graduation: _____

School's Location (City & State): _____

Year of Graduation (YYYY): _____

If you are a foreign medical school graduate, have you obtained an ECFMG certificate? ☐ NA ☐ Yes ☐ No

Indicate which certification you obtained and the year certified:

☐ ECFMG ☐ Fifth Pathway Year Certified (YYYY): _____

2. Internship Information

Facility name where your internship was served: _____

Location where your internship was served: _____

Specialty: _____ Dates (MM/YYYY–MM/YYYY): _____

3. Residency Information

Facility name where your residency was served: _____

Location where your residency was served: _____

Specialty: _____ Dates (MM/YYYY–MM/YYYY): _____

4. Have you undergone additional medical training? ☐ Yes ☐ No

If yes, indicate type: _____ Dates (MM/YYYY–MM/YYYY): _____

5. Specialty Information

Your medical specialty: _____

Your sub-specialty: _____

6. Are you certified by an approved specialty board? ☐ Yes ☐ No

If yes, list the certifying board name(s): _____

Date(s) of recertification (MM/YYYY): _____

7. List each state where you are licensed to practice, your license number, and the percentage of practice in each state.

State	License Number	% of Practice	Insurance Carrier

8. Indicate the name and locations of all facilities, including non-hospital facilities, where you hold staff or courtesy privileges.

Name	Location

9. List all the places where you have practiced your profession during the last five (5) years, including your current employer.

Facility or Practice Name	City & State	Dates (MM/YYYY to MM/YYYY)
		to
		to
		to
		to

10. Has any changes occurred in your practice or specialty during the last five (5) years? ☐ Yes ☐ No

If yes, describe the changes: _____

F. Classification

1. Indicate each of the following that you perform. Check each box that applies.

☐ **No Surgery**	No surgical procedures performed other than incision of boils and superficial abscesses, suturing of skin and superficial fascia or circumcision.
☐ **Minor Surgery**	Includes procedures performed under local anesthesia or assisting in major surgery on your own patients. Open reduction of fractures shall be considered minor surgery.
☐ **Obstetrical Procedures**	Obstetrical procedures and/or prenatal care beyond first trimester. **Cesarean sections shall be considered major surgery.**
☐ **Major Surgery**	All other types of surgery and operations performed under general or regional anesthesia. Includes — but is not limited to — removal of tumors, amputations, abortions, removal of any gland or organ, plastic surgery, or assisting in major surgery in other than your own patients.

2. Indicate the percentage of time you devote to the following medical and/or surgical activities. **(Total should = 100%)**

Non-Surgical

%	Activity	%	Activity
_____	Administrative Medicine	_____	Neurology
_____	Allergy	_____	Nutrition
_____	Anesthesiology	_____	Occupational Medicine
_____	Broncho-Esophagology	_____	Oncology
_____	Cardiovascular Disease	_____	Ophthalmology
_____	Dermatology	_____	Orthopedics
_____	Emergency Medicine	_____	Otology
_____	Endocrinology	_____	Otorhinolaryngology
_____	Family Practice / Gen. Practice	_____	Pain Management*
_____	Fetal & Maternal Medicine	_____	Pathology
_____	Forensic Medicine	_____	Pediatrics
_____	Gastroenterology	_____	Pharmacology - Clinical
_____	General Preventive Medicine	_____	Physiatry
_____	Genetic Counseling	_____	Physical Med./ Rehab.
_____	Geriatrics	_____	Psychiatry
_____	Gynecology	_____	Psychoanalysis
_____	Hematology	_____	Psychosomatic Medicine
_____	Hospitalist	_____	Public Health
_____	Infectious Disease	_____	Pulmonary Diseases
_____	Intensive Care Medicine	_____	Radiology
_____	Internal Medicine	_____	Rheumatology
_____	Laryngology	_____	Rhinology
_____	Neuroplastic Diseases	_____	Sports Medicine
_____	Nephrology	_____	Other*

Surgical

%	Activity	%	Activity
_____	Abdominal	_____	Obstetrics
_____	Bariatric	_____	Obstetrics-Gynecology
_____	Cardiac	_____	Ophthalmology
_____	Cardiovascular	_____	Orthopedic
_____	Colon & Rectal	_____	Orthopedic (Excluding Spinal Surgery)
_____	Dermatology	_____	Orthopedic (Including Spinal Surgery)
_____	Endocrinology	_____	Otorhinolaryngology
_____	Foot & Ankle	_____	Plastic
_____	Gastroenterology	_____	Plastic-Otorhinolaryngology
_____	General	_____	Thoracic
_____	Geriatrics	_____	Traumatic
_____	Gynecology	_____	Urological
_____	Hand	_____	Vascular
_____	Head & Neck	_____	Other*
_____	Laryngology		
_____	Neonatal		
_____	Nephrology		
_____	Neurosurgery		

***Describe in the Comments Section.**

3. Please check the medical procedures you perform from the list below.

- ☐ Autologous Fat Injection
- ☐ Anglography
- ☐ Arteriography
- ☐ Botox Injections
- ☐ Bronchoscopy
- ☐ Catheterization - arterial, cardiac, or diagnostic other than:
  - Occasional emergency insertion of pulmonary wedge, pressure recording catheters, or temporary pacemakers.
  - Urethral catheterization
  - Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen
- ☐ Chelation therapy
- ☐ Closed fracture reduction of displaced fractures
- ☐ Colonoscopy
- ☐ Cryosurgery - other than use on benign or premalignant dermatological lesions.
- ☐ Discograms
- ☐ Conscious Sedation
- ☐ Discograms
- ☐ ECT (describe): _____
- ☐ Epidurals
- ☐ ERCP (Endoscopic Retrograde Cholangiopancreatography)
- ☐ Lasers (describe): _____
- ☐ Laparoscopy
- ☐ Liposuction
- ☐ Mohs Surgery (Chemosurgery)
- ☐ Nonendoscopic Pneumatic Esophageal Balloon Dilation
- ☐ Needle Biopsy (describe): _____
- ☐ Percutaneous Tracheostomy
- ☐ Phlebography
- ☐ Radiation Therapy
- ☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts, and fistulae
- ☐ PEG (Percutaneous Endoscopic Gastrostomy)
- ☐ Other procedure by which the body or body cavity is penetrated or entered by use of a tube, needle, device, or ionizing radiation (describe): _____
- ☐ **NONE OF THE ABOVE**

G. Underwriting Questions *(Please read carefully.)*

1.	Has your medical or narcotics license ever been denied, suspended, voluntarily surrendered, revoked, or been subject to investigation or probationary terms in any jurisdiction?	☐ Yes	☐ No
2.	Have you ever been—or are you currently aware of—any complaint, investigation, disciplinary proceeding, or reprimand by any administrative agency, licensing agency, medical society or professional organization, hospital, or other medical facility?	☐ Yes	☐ No
3.	Has any hospital, medical association, medical society or medical board, licensing authority, or peer review organization notified you of its intention to consider imposing a change of status, penalties, privileges, participation, certification, or membership?	☐ Yes	☐ No
4.	Has your medical or narcotics license ever been denied, suspended, voluntarily surrendered, revoked, or been subject to investigation or probationary terms in any jurisdiction?	☐ Yes	☐ No
5.	Do you provide professional service for a county jail, prison, or other correctional facility?	☐ Yes	☐ No
6.	Have you ever been denied a medical license or been denied certification by a specialty board?	☐ Yes	☐ No
7.	Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	☐ Yes	☐ No
8.	Has your professional liability insurance ever been declined, canceled, non-renewed, refused, or renewed or issued with special terms? If yes, explain why and give name(s) of carriers(s) in **Comments Section**.	☐ Yes	☐ No
9.	Has any administrative agency, licensing entity, medical society, hospital, or professional organization ever requested you to be examined or evaluated by another physician because of an alleged mental condition, alcohol abuse, or drug dependency?	☐ Yes	☐ No
10.	Have you ever had an illness or physical disability that impairs or could tend to impair your ability to practice medicine or could put your patients at risk? (e.g., alcoholism, convulsive disorders, Hepatitis B, HIV positive, mental illness, multiple sclerosis, narcotics addiction rheumatoid arthritis, etc.) If yes, **a)** state illness or disability in the **Comments Section**, **b)** you must provide a statement from your physician with complete details of your illness or disability and attesting to your fitness to practice medicine.	☐ Yes	☐ No
11.	Have you ever been treated for alcohol or drug impairment or mental illness?	☐ Yes	☐ No
12.	Do you staff an emergency room for purposes other than to maintain hospital privileges? If yes, in the **Comments Section** provide an explanation that includes the hospital name, location, number of hours per month, and whether coverage is provided through another insurance carrier.	☐ Yes	☐ No
13.	Do you provide any diagnostic, consulting or other professional services to patients in other states? If yes, please provide an explanation in the **Comments Section**. Include the states, type of service, and the annual number of encounters.	☐ Yes	☐ No
14.	Are you engaged in any "moonlighting" activities? If yes, please provide the following in the **Comments Section**: number of hours per month, location, and scope of practice.	☐ Yes	☐ No

15. Are you interested in applying for coverage in excess of your primary and Health Care Stabilization Fund coverage? ☐ Yes ☐ No

If yes, complete the **Application for Claims-Made Excess Insurance**, available under the Insurance tab of the KAMMCO website.

16. Are you employed or contracted as a medical director or similar role? ☐ Yes ☐ No

If yes, please provide an explanation in the **Comments Section**, including the name of the facility.

17. Do you supervise non-employed allied health professionals (i.e. physician's assistants, advanced registered nurse practitioners, registered nurses, aestheticians, etc.)? ☐ Yes ☐ No

If yes, please include the full details in the **Comments Section**.

18. Do you render patients unconscious for treatment in your office or other non-hospital facility? ☐ Yes ☐ No

19. Do you perform surgery or obstetrical procedures at a location other than a licensed hospital? ☐ Yes ☐ No

If "yes," please provide an explanation in the **Comments Section**, including the location distance (travel time) to the nearest hospital in your explanation.

20. Do you work part-time? ☐ Yes ☐ No

If yes, please provide an explanation in the **Comments Section**, including the number of hours worked per week providing patient care, hospital rounds, administrative duties, phone calls and teaching.

21. Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility? ☐ Yes ☐ No

If yes, please complete a **Corporate Health Care Application** for each, if coverage is desired.

Application available under the Insurance tab of the KAMMCO website.

22. Do you practice in a staff, a surgi-center, or similar minor emergency clinic? ☐ Yes ☐ No

23. Are you employed by the Federal Government, or are you in the military service? ☐ Yes ☐ No

24. Have your Medicare or Medicaid privileges ever been suspended, revoked, voluntarily surrendered, sanction, or subject to investigation? ☐ Yes ☐ No

25. Do you practice in a direct primary care model? ☐ Yes ☐ No

If yes, what is your patient panel size? _____

26. Do you practice telemedicine or teleradiology in Kansas or in other states? ☐ Yes ☐ No

If yes, complete the **Telemedicine Supplemental Questionnaire**, available under the Insurance tab of the KAMMCO website.

H. Claim Information

1. Have any claims or suits ever been made against you, your employees, or any professional corporation, association or partnership to which you belong or have belonged arising out of the performance of professional services rendered or which should have been rendered by you or by any person for whose acts or omissions you are legally responsible?* ☐ Yes ☐ No

If yes, explain in the **Comments Section**.

*Please complete the **Claim Information Worksheet** for each claim, suit, demand or screening panel identified above. Make additional copies as needed. The **Claim Information Worksheet** is available under the Insurance tab of the KAMMCO website.

I. Comments

Section & Question Number	Explanation

Please attach additional pages, as needed.

Execution of this application by the applicant does not bind KAMMCO to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

I understand membership in good standing in the Kansas Medical Society is required for coverage with KAMMCO.

If a policy is issued, the policy will be issued on a claims-made basis and will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy.

The applicant represents the statements and answers made herein are true, and makes the same for the purpose of inducing KAMMCO to issue the policy for which application is hereby made. It is understood that this entire policy shall be void if, whether before or after a loss or claim, the applicant has intentionally concealed or misrepresented any material fact or circumstance concerning the insurance or subject thereof.

I authorize and consent to investigations of information bearing upon moral character, training, professional reputation, previous claims and suits, and fitness to engage in the activities authorized by my license to practice medicine, including authorization to every person or entity, public or private, to release to KAMMCO, any documents, records and other information bearing upon the foregoing. The undersigned further agrees that KAMMCO and all persons or organizations may rely upon a photocopy of this authorization, which shall be of equal validity with the original.

I authorize the Company to release a certificate of insurance to professional credentials verification services an/or health care facility medical or credentialing staff.

I understand and agree these investigations shall not be confined to information submitted in the application, but shall include any other sources of information deemed relevant by KAMMCO as may be authorized by law.

Signature of Applicant **Date**

Please return this application, along with any necessary attachments,
by email to underwriting@kammco.com or by fax to **785.232.4704**.

If you work with a KAMMCO agent, please submit this application directly to your agent.

Kansas Health Care Stabilization Fund Notice of Basic Coverage Form

(for policy periods effective on and after Jan. 1, 2022)

Kansas law requires the insurance company to forward this completed form to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the effective date of the basic policy. A copy of this completed form must also be given to the health care provider.

FOR HCSF USE ONLY

SECTION I – Health Care Provider Identification and Residency

Health Care Provider's Name:
Last name, first name, middle initial, and professional acronym, or full name of medical care facility or other type of health care provider

Health Care Provider's Legal Kansas Residence: | Kansas |
Street Address and City (For a hospital or other facility, or a business entity, this should be the legal location.) Zip Code

Daytime Phone Number:

Health Care Provider's Email Address:

Mailing Address:
(Optional, if not the same as legal residence) Street Address or P.O. Box, City, State, Zip Code

SECTION II - HCSF Coverage Limit

☐ $500,000/$1,500,000

Date Signed

Health Care Provider's Signature

Notice to Health Care Provider: *If you discontinue your professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact your licensing agency and request that your license be made inactive.*

SECTION III - Health Care Stabilization Fund Surcharge and Insurance Policy Information

					For Fund Classes 1 to 14	For Fund Classes 15 to 24	
HCSF Rate Classification Number	Provider's License Number	Fund Compliance Year	Basic Coverage Premium Amount	HCSF Class Group Number	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment
			$		$	%	$

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or reasons:

☐ The policy is issued for only part of a year and the surcharge was prorated based on the number of days divided by 365. The proration (rounded to the nearest whole percent) was ____ %.

☐ The policy is a unique part-time policy issued by the primary professional liability insurer (requires explanation below under "extraordinary circumstances"). The part-time factor used was ____ %.

☐ This Kansas resident health care provider has an active Missouri license. The applicable Missouri modification factor was included in the surcharge calculation and the factor used was ____ %.

Type of Primary Coverage Professional Liability Insurance Policy: ☐ Occurrence ☐ Claims Made

Insurance Company Name:

Name of Agent or Other Company Representative:

Policy Number:

Agent or Company Rep. Email Address:

Coverage Effective Date:

Agent or Company Rep. Phone Number:

Coverage Expiration Date:

For insurer explanation of extraordinary circumstances:

FOR HCSF USE ONLY

623 SW 10th Avenue
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www.kammco.com

Claim Information Worksheet

(Make additional copies, if necessary.)

No Claims: ☐ *(A signature is required, regardless of claim history.)*

Applicant's Name (First, MI, Last): _____

Patient's Name (First, MI, Last): _____ Patient's Gender: ☐ Male ☐ Female

Allegation:

Date of Incident (MM/DD/YYYY): _____ Date Reported (MM/DD/YYYY): _____

Insurance Carrier: _____ Location of Incident: _____

Was a lawsuit filed? ☐ Yes ☐ No Are/were you the primary defendant? ☐ Yes ☐ No

If you are/were not the primary defendant, please describe your involvement in the patient care:

Additional Defendants: _____

Claim Status: ☐ Open ☐ Closed Date Closed (MM/DD/YYYY): _____

If open, indicate the reserve amount. *(Required)* _____

If closed, indicate:

a. Method of closing: ☐ Dismissed ☐ Settled ☐ Judgment

b. Amount of settlement or judgment: $ _____

I understand information submitted herein becomes part of my **Professional Liability Insurance Application** as submitted.

_____ _____

Signature **Date**

Please return this form, along with your application, or email it directly to underwriting@kammco.com.
If you work with a KAMMCO guest agent, please submit directly to your agent.

623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
www.kammco.com

Telemedicine Supplemental Questionnaire

Name (First, MI, Last): _____ **KAMMCO Policy #** (if applicable): _____

Name of Employer (if applicable): _____

Definition of Telemedicine
The delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site. Telemedicine is to be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology, to provide or support health care and delivery that facilitates the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. ***K.S.A.40-2,211**

1. Do you practice telemedicine? ☐ Yes ☐ No
   - If yes, fill out this form in its entirety.
   - If no, it is not necessary to complete this form.

2. What specialty to do you practice? _____

3. What percentage of your medical practice is—or will be—dedicated to telemedicine: _____

4. List the state and the percentage of telemedicine you practice in each state.

5. Do you hold a medical license for each state in which you practice telemedicine? ☐ Yes ☐ No
   - If no, explain why below.

6. Identify the types and scope of telemedicine services you provide.

7. Have you been named in a claim tied to the telemedicine services you provide? ☐ Yes ☐ No
   – If yes, explain why below.

8. Do you have a written agreement or contract to provide telemedicine services? ☐ Yes ☐ No

9. Do you have additional or specialized procedures for ensuring privacy and security of patient information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) with regard to telemedicine? ☐ Yes ☐ No

10. Have policies and protocols been established which provide a means of maintaining and documenting e-visit records for continuity of care? ☐ Yes ☐ No

11. Do you use an informed consent specifically for the telemedicine encounter? ☐ Yes ☐ No

12. Have policies and protocols been established to identify when face-to-face visits may be necessary? ☐ Yes ☐ No

Signature of Applicant **Date**

Return this form together with your completed application to KAMMCO.

If you work with a KAMMCO agent, submit this form along with your completed application to your agent.

KANSAS MEDICAL SOCIETY
Established 1859

Physician Application

Full Name:_____

Designation: ❑ MD ❑ DO

Practice name: _____

Office address: _____
Street

_____
City State Zip Code

Home address: _____
Street

_____
City State Zip Code

Mailing Preference: ❑ Office address ❑ Home address

Billing Preference: ❑ Office address ❑ Home address

Office phone ( ) _____ Home phone ( ) _____

Office fax ( ) _____

Email address: _____

Kansas License: _____

Specialty: _____ Residency Date: _____

Medical School: _____ Degree Date: _____

Birthdate: _____/_____/_____
Month Day Year

Gender: ❑ Male ❑ Female

Spouse's name: _____

Contact KMS with questions about this form: (785) 235-2383.

What are the eligibility requirements for KMS membership?

To be eligible for membership in KMS, an individual must be:

- **A graduate of an accredited medical school holding the degree of Doctor of Medicine and/or Doctor of Osteopathy and be licensed to practice medicine in the state of Kansas, or**
- **A full-time student attending a recognized medical school in Kansas.**

How much are KMS dues?

Please refer to the chart below for information regarding our membership categories and current dues.

Do I have to join my county medical society to be a KMS member?

Yes. Our bylaws require physicians to belong to their county medical society in order to be a member of KMS. County medical society dues vary from county to county. Members who have questions about their county society should contact the President or Secretary of their county medical society.

2022 KMS dues

$500	Active
$250	Active – first year
$375	Active – second year
$115	Osteopathic Associate
$250	Out of State Associate
$250	Semi-Retired
$0	Student
$0	Emeritus

County society dues

$0	Barton
$0	Bourbon
$100	Butler-Greenwood
$45	Central Kansas
$0	Cimarron
$0	Clay
$0	Cloud
$0	Cowley
$60	Crawford-Cherokee
$0	Dickinson
$0	Douglas
$0	Flint Hills
$0	Ford
$0	Franklin
$0	Geary
$50	Harvey
$0	Iroquois
$50	Labette
$25	Leavenworth
$0	McPherson
$0	Miami
$0	Mitchell
$25	Neosho
$0	Northeast
$0	Northwest
$0	Pottawatomie
$0	Pratt
$0	Reno
$0	Republic
$0	Rice
$150	Riley
$150	Saline
$355	Sedgwick
$50	Shawnee
$0	Southeast
$0	Southwest