623 SW 10th Avenue
Topeka, KS 66612
1.800.232.2259
www.kammco.com

Physician and Surgeon Application for Claims-Made Professional Liability Insurance – New Business

Application Instructions and Information:

- Answer all questions fully and accurately.
- If you need more space for any response, use the **Comments Section** at the end of this application or attach additional pages.
- Be sure to sign and date the application where indicated.
- This application is subject to review and acceptance by the company and does not bind coverage. Additional information may be requested.
- Incomplete applications or missing information may delay the underwriting process.

Requested Effective Date: _____

Section A: *Applicant Information*

Applicant Name (First, MI, Last): _____

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

Designation: ○ MD ○ DO ○ Other (specify): _____ Sex: ○ Male ○ Female

Applicant's Residential/Home Information (P.O. Box Not Accepted):

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Mobile: _____ Email: _____

Applicant's Business Information (P.O. Box Not Accepted):

Street: _____ City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Email: _____

Business Manager or Contact Person Information:

Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Billing Information: Send billing information to: ○ Home ○ Business ○ Other (specify, list below): _____

Street: _____ City: _____ State: _____ Zip: _____

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 KMS Physician Application.

Note: If you are a Kansas physician, membership in good standing in KMS is required for coverage.

Section B: *Current and Previous Coverage*

1. Name of current or previous professional liability carrier: _____

2. Date that the 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 provide an explanation in **Comments Section** of this application.

4. What type of policy do/did you have?: ○ Claims-made ○ Occurrence

5. Did you purchase or receive a reporting endorsement (i.e., tail coverage)? ○ Yes ○ No

Section C: *Requested Coverage*

Kansas Providers

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

2. Indicate Health Care Stabilization Fund (HCSF) Limits: ☐ $500,000 / $1,500,000

Missouri Providers

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

4. Are you requesting **Prior Acts Coverage**? (See note below) ○ Yes ○ No

   If no, skip to **Section D: Practice Information**.

   If yes, what is the retroactive date? (MM/DD/YYYY): _____

5. 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 **Comment Section**.

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.

Section D: *Practice Information*

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

a. _____ **b.** _____

c. _____ **d.** _____

e. _____ **f.** _____

2. List each professional corporation, limited liability company, or partnership in which you have ownership.

Note: You must complete one **Corporate Healthcare Entity** application for each organization listed.

Healthcare Entity Name	Description of Your Interest in the Entity	Percentage of Total Practice

3. Do you, as an individual, employ, contract, or otherwise maintain an association with any other healthcare providers? ○ Yes ○ No

If yes, complete the following:

Type of Medical Professional	How Many?	Designation	Current Insurer
Physician/Surgical Assistant		○ Employee ○ Contractor	
Nurse Anesthetists		○ Employee ○ Contractor	
Nurse Midwives		○ Employee ○ Contractor	
Nurse Practitioners		○ Employee ○ Contractor	
Other (specify):		○ Employee ○ Contractor	

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

Note: You must complete one **Corporate Healthcare Entity** application for each organization listed.

Employee or Contractor Name	Their Specialty	Their Insurer

Section E: *Education, Training, and Work Experience*

1. **Medical School Information**

School of Graduation: _____ Graduation Year (YYYY): _____

School Location (City and State): _____

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

If yes, indicate which certification you obtained and the year certified:

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

2. **Internship Information**

Internship Facility: _____ Dates (MM/YYYY-MM/YYYY): _____

Facility Location (City and State): _____ Specialty: _____

3. **Residency Information**

Residency Facility: _____ Dates (MM/YYYY-MM/YYYY): _____

Facility Location (City and State): _____ Specialty: _____

4. **Fellowship Information**

Fellowship Facility: _____ Dates (MM/YYYY-MM/YYYY): _____

Facility Location (City and State): _____ Specialty: _____

5. **Specialty Information**

Medical Specialty: _____ Medical Sub-Specialty: _____

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

If yes, list the certifying board names: _____

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

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

State	License or Certification Number	Percentage

State	License or Certification Number	Percentage

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

Facility Name	Location (City and State)

Facility Name	Location (City and State)

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

Facility or Practice Name	City and State	Dates MM/YYYY to MM/YYYY
		to
		to
		to
		to
		to

10. Has there been any change in your practice or specialty during the last five (5) years? ○ Yes ○ No

If yes, please specify: _____

Section F: *Classification*

1. Indicate each of the following 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 the first trimester. Cesarean sections shall be considered major surgery.
☐ Major Surgery	All other types of surgery and operations performed under general or regional anesthesia. This 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 on anyone 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
_____	Fam. or Gen. Practice	_____	Pain Management*
_____	Fetal & Maternal Medicine	_____	Pathology
_____	Forensic Medicine	_____	Pediatrics
_____	Gastroenterology	_____	Pharmacology - Clinical
_____	Gen. 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 (specify): _____		

SURGICAL

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

*Describe in the **Comments Section** at the end of this application.

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

- ☐ Autologous Fat Grafting
- ☐ Anglography
- ☐ Arteriography
- ☐ 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
- ☐ Cyrosurgery - other than use on benign or pre-malignant dermatological lesions
- ☐ Discograms
- ☐ Conscious Sedation
- ☐ ECT (describe):
- ☐ Epidurals
- ☐ ERCP (Endoscopic Retrograde Cholangiopancreatography)
- ☐ Lasers (describe):
- ☐ Laparoscopy
- ☐ Liposuction
- ☐ Mohs Surgery (Chemosurgery)
- ☐ Nonendoscopic Pneumatic Esophageal Balloon Dilation
- ☐ Needle Biopsy (describe):
- ☐ Percutaneous Tracheostomy
- ☐ Phelbography
- ☐ 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**

Section G: *Underwriting Questions*

1. Has your medical or DEA 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. Do you provide professional service for a county jail, prison, or other correctional facility? ○ Yes ○ No

5. Have you ever been denied a medical license or been denied certification by a specialty board? ○ Yes ○ No

6. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ○ Yes ○ No

7. Has your professional liability insurance ever been declined, canceled, non-renewed, refused, or renewed or issued with special terms? ○ Yes ○ No

   If yes, explain why and give name(s) of carriers(s) in the Comments Section.

8. Within the last seven (7) years, has any administrative agency, licensing entity, medical society, hospital, or professional organization requested you to be examined or evaluated by another physician because of an alleged mental condition, alcohol abuse, or drug dependency. ○ Yes ○ No

9. Within the last seven (7) years, have you 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? ○ Yes ○ No

   If yes, **a)** state the illness or disability in the **Comments Section**, and **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.

10. Within the last seven (7) years, have you been treated for alcohol or drug impairment or mental illness? ○ Yes ○ No

11. Do you provide services in any hospital Emergency Room setting? ○ Yes ○ No

    If yes, is the emergency care:

    a) Required for staff privileges? ○ Yes ○ No

    b) For your patients only? ○ Yes ○ No

    c) Moonlighting? ○ Yes ○ No

    i) How many hours: _____

    ii) Locations: _____

    iii) Do you work for a Locums Company? ○ Yes ○ No

12. Do you provide any diagnostic, consulting, or other professional services to patients in other states? ○ Yes ○ No

    If yes, provide the following in the Comments Section. Include the states, type of service, and the annual number of encounters.

13. Are you engaged in any "moonlighting" activities? ○ Yes ○ No

    If yes, provide the following in the Comments Section. Include the states, type of service, and the annual number of encounters.

14. Are you employed or contracted as a medical director or similar role? ○ Yes ○ No

    If yes, identify the name of the facility and detail your responsibilities in the Comments Section.

15. Do you maintain practice agreements or collaboration agreements as required by state law? ○ Yes ○ No

    If yes, do they carry their own insurance? ○ Yes ○ No

    - **Please list the names of providers, their locations, and practice names in the Comments Section.**

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

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

    If yes, provide an explanation in the Comments Section. Include the location distance (i.e., travel time)to the nearest hospital in your explanation.

18. Do you work part-time? ○ Yes ○ No

If yes, provide an explanation in the Comments Section. Include the number of hours you work per week providing patient care, hospital rounds, administrative duties, phone calls, and teaching.

19. Do you own or operate an ambulatory surgical center, urgent care facility, minor emergency care facility, laboratory, or other outpatient facility? ○ Yes ○ No

20. Are you employed by the Federal Government, or are you in the military services? ○ Yes ○ No

21. Do you practice in a direct primary care model? ○ Yes ○ No

If yes, what is your patient panel size: _____

22. Do you participate in clinical trials? ○ Yes ○ No

If yes, provide an explanation in the Comments Section.

23. Do you use any non-FDA approved devices, drugs, or procedures. ○ Yes ○ No

If yes, provide an explanation in the Comments Section.

24. Are you interested in applying for coverage in excess of your primary Health Care Stabilization Fund coverage? ○ Yes ○ No

If yes, complete an application for Physician and Surgeon Excess Liability.

Telemedicine

25. Do you practice telemedicine or teleradiology in Kansas or in other states? ○ Yes ○ No

If yes, answer the following:

a) What percentage of your medical practice is—or will be—dedicated to telemedicine? _____

b) List the state and the percentage of telemedicine you practice in each state:

State	%	State	%	State	%	State	%	State	%	State	%

c) Do you hold a medical license for each state in which you practice? ○ Yes ○ No

If no, provide an explanation in the **Comments Section**.

Section H: *Claim Information*

Have any claims or suits ever been made against you, your employees, or any professional corporation, association, or partnership with which you are or have been affiliated, arising out of professional services rendered—or that 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,** and complete, and attach to your application, one **Claim Information Worksheet** for each claim, suit, demand, or screening panel identified above. Make additional copies, as needed.

Section G: *Comments*

1. Use this section to add additional information requested in the application above. Attach additional pages, if necessary.

Section and Question Number	**Explanation**

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 reply 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 and/or healthcare 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 _____ **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.

623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
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): _____

Allegation:

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

Insurance Carrier: _____ Location of Incident: _____

Was a Lawsuit Filed? ○ Yes ○ No Are or were you the primary defendant? ○ Yes ○ No

Additional Defendants: _____

Please describe your involvement in the patient's care:

Claim Status:

○ Open ○ Closed: _____
Date Closed (MM/DD/YYYY)

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

If **CLOSED**, indicate the following:

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

b. Amount of settlement or judgement paid on your behalf: _____

I understand the information submittedherein becomes part of my Professional Liability Insurance Application as submitted.

_____ _____
Signature Date

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

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

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 ☐ Other

Spouse's name:_____

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

KANSAS MEDICAL SOCIETY
Established 1859

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.

2026 KMS Dues

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

County Medical Society Dues

$0	Anderson	$0	Flint Hills	$0	Northeast
$0	Atchison	$0	Ford	$0	Northwest
$0	Barton	$0	Franklin	$0	Pottawatomie
$0	Bourbon	$0	Geary	$0	Pratt
$100	Butler-Greenwood	$50	Harvey	$0	Reno
$60	Central Kansas	$0	Iroquois	$0	Republic
$0	Cimarron	$0	Johnson-Wyandotte	$0	Rice
$0	Clay	$50	Labette	$150	Riley
$0	Cloud	$25	Leavenworth	$0	Saline
$0	Cowley	$0	McPherson	$375	Sedgwick
$75	Crawford-Cherokee	$0	Miami	$50	Shawnee
$0	Dickinson	$0	Mitchell	$0	Southeast
$0	Douglas	$50	Neosho	$0	Southwest