California Medical Association Alliance Membership Application

Personal Information

Name _____

Address _____

City/Zip _____

Home Phone ( ) _____

Work Phone ( ) _____

FAX ( ) _____

Cell ( ) _____

Email _____

Spouse/Partner Name _____

Spouse/Partner Specialty/Profession _____

_____

County Medical Society _____

Volunteer Interest

☐Community Health
☐Legislation
☐Membership
☐Financial Development
☐Medical Family Support
☐Programs & Events
☐Leadership Development
☐Other

☐Regular Membership
(Physician or Physician Spouse/Partner, Widow or Widower)

☐Sustaining Membership
(Retired physician or spouse/partner of retired or deceased physician)

☐Physician-in-Training Membership
(Medical Student, Intern, Resident, Fellow or spouse/partner)

☐Friend of Medicine (Associate Membership)
(A member who fits none of the above categories and who supports the family of medicine. Must be sponsored by an active Alliance member.)

Sponsor's Name _____

Alliance Dues

☐Regular Membership.....$ 60.00
(Local & State)
☐Sustaining Membership.....$ 30.00
☐PIT Membership.....Courtesy
(AMAA Dues $10.00. Scholarships available.)
☐Friend of Medicine.....$ 60.00
☐AMAA Dues.....$ 50.00
(Recommended)

Total Dues $ _____

IT'S TIME TO RENEW YOUR MEMBERSHIP OR JOIN US!

☐My check is enclosed made payable to CMAA.

Donation to CMAA Foundation.....$_____

☐I prefer to charge my membership to my credit card.
($4.00 Service Charge)

Total Enclosed.....$_____

Signature _____

Card# _____ Expiration Date _____

☐Visa ☐MasterCard ☐American Express

Mail or FAX Application to:
CMA Alliance, PO Box 12605, Bakersfield, CA 93389-2605
FAX: 559-435-0184
For further information contact: alliance@cmanet.org, http://www.cmaalliance.com