California Medical Association Alliance Membership Application

Personal Information

Name _____

Address _____

City / Zip _____

Home Phone ( ) _____

Work Phone ( ) _____

Fax ( ) _____

Cell ( ) _____

Email _____

Spouse / Partner Name _____

_____

Spouse / Partner Profession _____

_____

Volunteer Interest

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

Membership Categories

- ☐ Please accept my membership application.
- ☐ Regular Membership
  (Physician or Physician Spouse / Partner)
- ☐ Sustaining Membership
  (Retired physician or spouse / partner of retired or deceased physician)
- ☐ Student 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.....$ 110.00
  (Local & State $60, National $50)
- ☐ Sustaining Membership.....$ 80.00
- ☐ Student Membership.....$ 15.00
  (Scholarships available upon request)
- ☐ Friend of Medicine.....$ 60.00
- ☐ CALPAC.....$ 25.00

Total Dues $

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

- ☐ My check is enclosed made payable to CMAA.
- ☐ I prefer to charge my membership to my credit card.
  ($4.00 Service Charge)

Donation to CMAA Foundation.....$_____

Total Enclosed.....$_____

Signature_____ Card #_____ Expires_____

☐ Visa ☐ Mastercard ☐ American Express

Send or FAX Application to:
CMA Alliance, 1201 J Street #300
Sacramento, CA 95814
FAX 916-551-2029

For further information contact:
CMA Alliance 916- 551-2028
www.cmaalliance.com