AMA Alliance Dues Submission Cover Sheet for Counties

Submitted by:

State:_____ County:_____Batch #_____

Date of submission:_____ Membership activation dates:_____

Name of Treasurer or Officer:_____

Address:_____

City:_____ State:_____ Zip:_____

Daytime phone:_____

Fax:_____

Email:_____

Submission Details:

Member category	Yearly dues	Total number of members	Total dues submitted
Regular or associate spouse	$50		
Physician	$50		
Resident spouse	$10		
Resident	$10		
Medical student	$10		
Medical student spouse	$10		

Payment: Checks should be made payable to AMA Alliance.

Questions?: Call: 312.464.4470; Email: amaa@ama-assn.org

Headquarters Use Only:

Date dues received:	
Check:	
Total amount:	
Received by:	
MR:	