



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 _____

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

Volunteer Interest

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

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. Donation to CMAA Foundation.....\$ _____
- I prefer to charge my membership to my credit card. Total Enclosed.....\$ _____
(\$4.00 Service Charge)

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 President's Direct Number: 1-800-492-4054
alliance@cmanet.org, www.cmaa.net