

# NMA Membership Application

## Personal Information

Name—Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

• Preferred Mailing Address:  Home  Office

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

FAX \_\_\_\_\_ E-mail \_\_\_\_\_

•  Male  Female • Date of Birth \_\_\_\_\_ • SSN# \_\_\_\_\_

• Professional Degree:  M.D.  Other (specify) \_\_\_\_\_ • NO. of years in Medical Practice \_\_\_\_\_

• Medical School Attended \_\_\_\_\_ • Year Degree Conferred \_\_\_\_\_

• Primary Medical Specialty \_\_\_\_\_ • Bd.Cert.: \_\_\_\_\_

• Licensure: Number(s) \_\_\_\_\_ State(s) of Licensure \_\_\_\_\_ Exp. Date(s) \_\_\_\_\_

• Name of your NMA state society \_\_\_\_\_ • Name of your local NMA society \_\_\_\_\_

## NMA Dues Schedule \*

The membership period in the National Medical Association is for the calendar year, January 1 through December 31.

<input type="checkbox"/> Physician/Regular Membership .....	\$495	<b>Associate Membership *</b>
<input type="checkbox"/> First Time Physician Member .....	\$250	<input type="checkbox"/> Full Time Medical Teaching Faculty .....
<input type="checkbox"/> Doctors of Osteopathic Medicine .....	\$495	<input type="checkbox"/> Member Non-U.S. Medical Society .....
<input type="checkbox"/> Physician/First Year in Practice .....	\$215	<input type="checkbox"/> Medical missionary in non U.S. country .....
<input type="checkbox"/> Physician/Second Year in Practice .....	\$345	<input type="checkbox"/> Doctorate/PH.D. in the Medical or Health Profession .....
<input type="checkbox"/> Physician/Active Duty Military .....	\$255	<input type="checkbox"/> International Membership .....
<input type="checkbox"/> Resident Fellow .....	\$40	
<input type="checkbox"/> Medical Student .....	\$20	
<input type="checkbox"/> Emeritus (pre-approval required) .....	waived	

\*Associate members have no voting representation and may not hold office.

## Payment

Check enclosed: (Make check payable to National Medical Association)

Credit Card:  AMEX  VISA  MasterCard  Discover  Diners

Card# \_\_\_\_\_

Exp. Date \_\_\_\_\_ V Code (last 3 digits on back of card) \_\_\_\_\_

Cardholder Name \_\_\_\_\_ Signature \_\_\_\_\_

## Personal Information

Check One Only

- Clinical Practice
- Administration
- Research
- Retired
- Full time teaching (in a recognized medical institution)
- Medical missionary work or teaching in non-U.S. country)
- Other (specify) \_\_\_\_\_

## Primary NMA Medical Section

- Aerospace, Military and Occupational Medicine
- Allergy, Immunology and Asthma
- Anesthesiology
- Basic Science
- Community Medicine and Public Health
- Dermatology
- Emergency Medicine
- Family Practice
- Internal Medicine
- Medical Administrators
- Neurology/Neurosurgery
- Obstetrics and Gynecology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Plastic and Reconstructive Surgery
- Postgraduate Physicians
- Psychiatry and the Behavioral Sciences
- Radiology
- Surgery
- Urology
- Womens Health

**National Medical Association, P.O. Box 631062, Baltimore, MD 21263-1062, 202-347-1895 phone, 202-783-5193 fax, www.NMAnet.org**

\* Membership Dues are non refundable.