Marin Medical Society / California Medical Association

MEMBERSHIP APPLICATION

Name (as shown on CA MD/DO License) CA MD/DO License Number

Please put a check mark by the address (Office or Home) you'd like us to use for MMS/CMA correspondence and publications.

☐ Office Address

Office Telephone Number Office Fax Number E-mail Address

☐ Home Address:

Home Telephone Number Spouse's Name Social Security Number

Date of Birth Place of Birth

Specialty and Year of Board Certification Subspecialty and Year of Board Certification Subspecialty and Year of Board Certification

Medical School Yr Graduation Year

Internship Yr to Yr

Residency Yr to Yr

Previous California Medical Association (CMA) Active member? ☐ yes ☐ no ☐ **I am interested in AMA membership.**

Indicate mode of practice:
☐Solo/Small Grp (1-4) ☐Medium Grp (5-149) ☐ Large Grp (150-999) ☐ Very Large Grp (1,000+) ☐ Academic ☐ Hospital-Based
☐Government-Employed ☐ Administrative Medicine

The foregoing is true and complete, and I endorse the Principles of Medical Ethics of MMS, CMA and AMA (available at cmanet.org).
Signature ____________________________ Date____________________________

Indicate your Membership Status:

☐ **$1095** Active *(practicing in Marin County with a physician's & surgeon's certificate issued by the MBC or OMBC).*
☐ **$547.50** Active, New Member *(never been a CMA member or applying during first year in practice).*
☐ **$547.50** Active, Half time and 65+Yrs *(working 1- 20 hours/week and are 65+ years of age).*
☐ **$547.50** Government *(receive more than 50 percent of their practice income from county, state or federal employment).*
☐ **$303** Multiple *(physician who is an active member of another CMA component medical society).*
☐ **$252** YPS (Young Physician)

Notes: 1) **All applicants (excluding residents and transfers from another medical society) pay an application fee of $200. Please submit with application.**

METHOD OF PAYMENT: ☐**CHECK ENCLOSED: $**_______________

PLEASE CHARGE $______________**to my credit card: Please indicate which card below.**

Card Type: (Circle One) MasterCard VISA **Account Number:** ______________________________ **Exp.:** __________

Signature:

Fax completed application to 415/924-2749, or
send to Marin Medical Society, PO Box 246, Corte Madera, CA 94976 (Telephone: 415/924-3891)