

# Membership Application Form

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

## PERSONAL INFORMATION

NAME - LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

PREFERRED MAILING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_\_) \_\_\_\_\_ FAX \_\_\_\_\_ E-MAIL \_\_\_\_\_

•  Male  Female • Date of Birth: \_\_\_\_\_ • SS# \_\_\_\_\_

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

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

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

• 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.....\$445      | <input type="checkbox"/> Emeritus (pre-approval required).....waived    |
| <input type="checkbox"/> Physician/First Year in Practice.....\$190  | <b>Associate Membership*</b>  |
| <input type="checkbox"/> Physician/Second Year in Practice.....\$320 | <input type="checkbox"/> Full time Medical Teaching Faculty.....\$210   |
| <input type="checkbox"/> Physician/Active Duty Military .....\$255   | <input type="checkbox"/> Member Non-US Medical Society.....\$210        |
| <input type="checkbox"/> Resident/Fellow.....\$ 40                   | <input type="checkbox"/> Medical Missionary in Non-US Country.....\$210 |
| <input type="checkbox"/> Medical Student .....\$ 20                  |   |
- \*Only listed categories are eligible for Associate membership.  
Associate members have no voting representation and may not hold office.

## PAYMENT

- Dues check enclosed
- Charge dues to credit card:  AMEX  VISA  MasterCard  Discover  Diners
- Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_
- Cardholder Name \_\_\_\_\_ Signature \_\_\_\_\_

## PROFESSIONAL ACTIVITY

CHECK ONE ONLY

- Clinical practice  Research
- Administration  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

SELECT ONE

- |  |   |
|--|---|
| <input type="checkbox"/> Aerospace, Military and Occupational Medicine | <input type="checkbox"/> Ophthalmology                          |
| <input type="checkbox"/> Allergy and Immunology                        | <input type="checkbox"/> Orthopaedics                           |
| <input type="checkbox"/> Anesthesiology                                | <input type="checkbox"/> Otolaryngology                         |
| <input type="checkbox"/> Basic Science                                 | <input type="checkbox"/> Pathology                              |
| <input type="checkbox"/> Community Medicine and Public Health          | <input type="checkbox"/> Pediatrics                             |
| <input type="checkbox"/> Dermatology                                   | <input type="checkbox"/> Physical Medicine and Rehabilitation   |
| <input type="checkbox"/> Emergency Medicine                            | <input type="checkbox"/> Plastic and Reconstructive Surgery     |
| <input type="checkbox"/> Family Practice                               | <input type="checkbox"/> Psychiatry and the Behavioral Sciences |
| <input type="checkbox"/> Internal Medicine                             | <input type="checkbox"/> Radiology                              |
| <input type="checkbox"/> Medical Administrators                        | <input type="checkbox"/> Surgery                                |
| <input type="checkbox"/> Neurology/Neurosurgery                        | <input type="checkbox"/> Urology                                |
| <input type="checkbox"/> Obstetrics and Gynecology                     |   |

FAX this form with your credit card information to 202-783-5193 (if you fax, do not also mail), or MAIL this form with either a check payable to National Medical Association or credit card information to (if you mail, do not also fax): National Medical Association P.O. Box 631062, Baltimore, MD 21263-1062 or ONLINE at [www.NMANet.org](http://www.NMANet.org)