

National Medical Association 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: _____ • 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.

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|--|--------|--|-------|
| <input type="checkbox"/> Physician/Regular Membership | \$445 | Associate Membership* | |
| <input type="checkbox"/> Doctors of Osteopathic Medicine | \$445 | <input type="checkbox"/> Full time Medical Teaching Faculty | \$210 |
| <input type="checkbox"/> Physician/First Year in Practice | \$190 | <input type="checkbox"/> Member Non-U.S. Medical Society | \$210 |
| <input type="checkbox"/> Physician/Second Year in Practice | \$320 | <input type="checkbox"/> Medical Missionary in Non-U.S. Country | \$210 |
| <input type="checkbox"/> Physician/Active Duty Military | \$255 | <input type="checkbox"/> Doctorate/Ph.D. in the Medical or Health Profession | \$210 |
| <input type="checkbox"/> Resident/Fellow | \$40 | <input type="checkbox"/> International Membership | \$210 |
| <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
 Credit Card: AMEX VISA MasterCard Discover Diners

Card# _____

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

Cardholder Name _____ Signature _____

Professional Activity

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 and Immunology
- 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
- Psychiatry and the Behavioral Sciences
- Radiology
- Surgery
- Urology
- Women's Health