

# PMA SAN DIEGO

PHILIPPINE MEDICAL ASSOCIATION ON SAN DIEGO INC.



## MEMBERSHIP RENEWAL FORM

1615 Sweetwater Rd. Suite D

National City, Ca 91950

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*"The Association You Know. The Doctors You Trust"*

Date: \_\_\_\_\_

\*PHYSICIAN NAME \_\_\_\_\_ \*DOB \_\_\_\_\_

\*SPOUSE \_\_\_\_\_ \*DOB \_\_\_\_\_

Home Address will be handled with extreme confidentiality

Home: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Mobile # : \_\_\_\_\_

Fax # \_\_\_\_\_ Email Address: \_\_\_\_\_

Contact #: \_\_\_\_\_

### OFFICE INFORMATION

\*Office Address (1) \_\_\_\_\_

\*Office Phone # \_\_\_\_\_ Fax # : \_\_\_\_\_

Office Address (2): \_\_\_\_\_

Office Phone # \_\_\_\_\_ Fax # : \_\_\_\_\_

\*State License(s): 1. \_\_\_\_\_ 2. \_\_\_\_\_

\*Specialty : \_\_\_\_\_ Subspecialty: \_\_\_\_\_

Medical School \_\_\_\_\_ Year Graduated: \_\_\_\_\_

Post Graduate Training(s):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### \*REQUIRED

#### CURRENT PRACTICE

\_\_\_\_\_ 1.Solo \_\_\_\_\_ 2.Group \_\_\_\_\_ 3.Employed \_\_\_\_\_ 4.Military \_\_\_\_\_ 5.Retired \_\_\_\_\_ 6.Others

\$ \_\_\_\_\_

**YEARLY DUES**

\$ \_\_\_\_\_

**LIFETIME DUES**

\_\_\_\_\_

**Signature Applicant**