

MONUMENTAL CITY MEDICAL SOCIETY MEMBERSHIP APPLICATION

APPLICANT INFORMATION

Name:		
Home Address:		
City:	State:	ZIP Code:
Date of Birth:	Home Phone:	Other Phone:
<input type="checkbox"/> New <input type="checkbox"/> Renewal	MD License#:	Year Received:

OFFICE INFORMATION

Name of Practice:		
Office Address:		How long?
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:
Practice Information:	<input type="checkbox"/> Solo <input type="checkbox"/> Partnership <input type="checkbox"/> Group	Referred By:
Hospital Affiliations:		
Where Should Mail Be Sent: <input type="checkbox"/> Home <input type="checkbox"/> Office		

MEDICAL BACKGROUND

Medical School:		
Date Completed:	Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Specialty:

SPOUSE INFORMATION IF JOINT MEMBERSHIP

Name:	
Date of Birth:	Phone:

SPOUSE EMPLOYMENT INFORMATION

Name of Practice:		
Office Address:		How long?
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:

CATEGORY OF MEMBERSHIP

<input type="checkbox"/> Doctor \$260.00	<input type="checkbox"/> Affiliate \$160.00	<input type="checkbox"/> Resident/Fellow \$85.00
Are You A Member of the NMA?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Received & Paid:

PAYMENT OPTIONS (JOINT MEMBERSHIP IS DOUBLE)

Please bill my credit card <input type="checkbox"/> Visa <input type="checkbox"/> Master Card <input type="checkbox"/> American Express <input type="checkbox"/> Check				
Credit Card#:			Exp. Date: /	

SIGNATURES

I hereby certify that I have answered all of the questions on this application to the best of my knowledge.

Applicant Signature:	Date:
Spouse Signature (only for joint membership):	Date:

MAIL FORM WITH CHECK PAYABLE TO:
MONUMENTAL CITY MEDICAL SOCIETY
1211 CATHEDRAL STREET
BALTIMORE, MD 21201

FOR FURTHER INFORMATION: CALL BONITA CHURCH AT 410-244-1500