

MEMBERSHIP APPLICATION



LACMA
Serving L.A. County Doctors Since 1871



SECTION ONE - DEMOGRAPHIC INFORMATION

Name (As Shown on CA/MD/DO License) CA MD/DO License # Date of Birth (mm/dd/yyyy)

I am a previous California Medical Association (CMA) active member.

I am joining LACMA/CMA for (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Networking with other doctors | <input type="checkbox"/> Jury duty assistance |
| <input type="checkbox"/> Support LACMA's and CMA's political/legislative agenda | <input type="checkbox"/> Reimbursement and legal assistance |
| <input type="checkbox"/> Discounts on valuable services | <input type="checkbox"/> Other (please explain): _____ |
| <input type="checkbox"/> Professional obligation | |

I was referred to LACMA by (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Magazine or other advertisement | <input type="checkbox"/> A colleague - |
| <input type="checkbox"/> LACMA staff member | Colleague's name: _____ |
| <input type="checkbox"/> Membership solicitation by letter, fax or email | <input type="checkbox"/> Other (please explain): _____ |

Languages I speak: _____

My ethnicity is: _____

My malpractice insurer is: _____

My gender is: Female Male

SECTION TWO - CONTACT INFORMATION

Office Contact Information

Medical Group Name <input type="text"/>	Phone (Including Area Code) <input type="text"/>
Street Address 1 <input type="text"/>	Fax (Including Area Code) <input type="text"/>
Street Address 2 <input type="text"/>	E-Mail Address <input type="text"/>
City <input type="text"/>	Office Manager's Name <input type="text"/>
State <input type="text"/>	Office Manager's E-Mail Address <input type="text"/>
Zip <input type="text"/>	
My Practice's Web Site Address <input type="text"/>	

Home Contact Information

Street Address 1 <input type="text"/>	Phone (Including Area Code) <input type="text"/>
Street Address 2 <input type="text"/>	Fax (Including Area Code) <input type="text"/>
City <input type="text"/>	E-mail Address <input type="text"/>
State <input type="text"/>	
Zip <input type="text"/>	
My Spouse's Name <input type="text"/>	My Preferred LACMA/CMA Contact Location <input type="checkbox"/> Office <input type="checkbox"/> Home

Fax application to: (213) 226-0353

Mail application to: LACMA • 707 Wilshire Blvd., Suite 3800 • Los Angeles, CA • 90017

Need Help? Call us at (213) 226-0313



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SECTION THREE - PRACTICE INFORMATION

Mode of Practice (please check one):

- Solo/Small Group (1-4) Very Large Group (1,000+) Government-employed
 Medium Group (5-149) Academic Administrative Medicine
 Large Group (150-999) Hospital-based

NPI Number: _____

SECTION FOUR - EDUCATION & TRAINING

Specialty Certifying Board Year of Certification

Subspecialty Certifying Board Year of Certification

Medical School Year of Graduation

Internship Location Years to

Residency Location Years to

Postgraduate/Fellowship Years to

SECTION FIVE - ATTESTATION

IMPORTANT: PLEASE CHECK BEFORE PROCEEDING

The foregoing is true and complete, and I endorse the Principles of Medical Ethics of LACMA-CMA (available at cmanet.org). By providing the fax number and e-mail address on this application, I agree to receive important fax and e-mail communications from the association.

SECTION SIX - MEMBERSHIP TYPE & PAYMENT INFORMATION

Membership Type (please check one):

- First-time member: \$555 (Full dues reached by year 3) Former member: \$1,150 (Full dues)
 Young physicians: \$319 (Full dues reached by year 5) Resident physicians: \$60

Sign me up for a LACMA-CMA membership for the duration of my internship/residency/post-grad programs in L.A. County

\$35.00 of LACMA dues is directed to LACPAC, LACMA Political Action Committee, to support candidates for public office. Members who object to having their dues directed to political action activities may check the box below and the \$35.00 will be redirected to the Patient Care Foundation of Los Angeles, which works to address the present day needs of doctors and their patients in Los Angeles County.

I prefer my political support money to be deposited in the Patient Care Foundation of Los Angeles County Fund.

A portion of CMA dues is directed to CALPAC, CMA's political action committee, to support candidates for public office who share CMA's philosophy. Members who object to having their dues directed to political action activities may check the box below and the \$50.00 will be redirected to the MICRA Education Fund, a fund to protect and enhance the tort reform provisions of MICRA.

I prefer my political support money to be deposited in the MICRA Education Fund.

Los Angeles County Medical Association
707 Wilshire Boulevard, Suite 3800
Los Angeles, California 90017
(213) 683-9900
www.lacmanet.org

California Medical Association
1201 J Street, Suite 200
Sacramento, California 95814
1 (800) 786-4262
www.cmanet.org

Payment Type (please check one):

- My check is enclosed for my LACMA-CMA membership.
(Please make checks payable to LACMA)
 Please charge my dues to my credit card.

Card Type (please check one):

- MasterCard Visa American Express

Account Number Expiration (mm/yyyy)