



Membership Application

2550 Corporate Place, Suite C202-Monterey Park, CA 91754
Phone: (323) 266-2455 Fax: (323) 266-2453

Date: _____

Please Check One: New Member Renewal

General Information

Name: _____ Credentials: _____

Office Address: _____

City/State/Zip Code: _____

Office Telephone: _____ Fax: _____ E-mail: _____

Home Address: _____

City/State/Zip Code: _____

Home Telephone: _____ Fax: _____ E-mail: _____

Preferred Mailing Address: Office Home Preferred E-mail: Office Home

Medical Specialty: _____ Sub-Specialty: _____

California Medical License Number: _____

Gender: Female Male Ethnicity: (please be specific) _____

Bilingual (English/Spanish): Fluent Some Spanish Bilingual Staff: Yes No

Education

Undergraduate: _____ Grad. Year: _____

Medical School: _____ Grad. Year: _____

Residency: _____ Grad. Year: _____

Other Training: _____ Grad. Year: _____

Board Certification: Yes No Year: _____

Name of Board(s): _____

Academic Affiliations

Title: _____ Appt. Dates: _____

School: _____

Professional Affiliation(s)

AMA CMA Other: _____ Other: _____

Participation Options

I am interested in participating in the following CaLMA Committee(s)/Event(s):

- Scholarships Fundraising Public Policy
- CME Programs Health Fairs Bylaws
- Speakers Bureau Women’s Health Mentoring
- Chapter Leadership

Annual Dues

Physician-

\$100.00 – One Year General Membership

- *La Consulta*, a quarterly newsletter filled with topics of interest & member-submitted articles, opinions and comments; Directory listing
- FREE CME and other educational programs throughout the year; Chapter participation;
- Additional benefits throughout the year;

\$250.00 - One-year Directory Membership

- Includes General Membership benefits *PLUS* electronic listing on-line in the Latino Physician Directory, ½ page Ad in *La Consulta*.

\$350.00 - One-Year *Medico* Membership

- Includes Directory Membership benefits *PLUS* running banner on CaLMA Website and e-newsletter, and a full page ad in *La Consulta*.

Resident- \$35.00 Medical Student- Free

Allied Health Professional- \$35.00 (including DPM, PA, & NP)

Enclosed is my payment in the amount of \$ _____.

Check (Payable to CaLMA)

Credit Card

AMEX Discover MasterCard Visa

Card Number: _____

Amount \$ _____ Expiration Date: _____

Billing Address: _____

Signature: _____ Date: _____

Mail Check and Application to:
CaLMA Membership Services
2550 Corporate Place Suite C202
Monterey Park, CA 91754

