



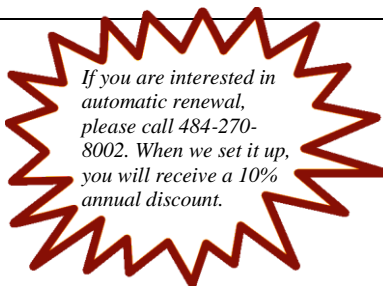
CATHOLIC MEDICAL ASSOCIATION

Upholding the Principles of the Catholic Faith in the Science and Practice of Medicine

2018 NEW MEMBER APPLICATION

Membership benefits include spiritual and professional support; subscription to *The Linacre Quarterly* and *The Pulse of Catholic Medicine Magazine*; educational opportunities and networking; email updates and action alerts; discounted registration to our Annual Conference. Join online www.cathmed.org/membership

Membership Categories	Dues (Check or Credit Card)
Physician Members (M.D., D.O.): Active First Year in Practice Semi-Retired (<20 Hours per Week) Retired (0 Hours per Week) Residents or Fellows Clergy or Religious who are Physicians Uniformed Service (Active Duty Only)	___ \$425.00 ___ \$200.00 ___ \$175.00 ___ \$100.00 ___ \$50.00 ___ \$75.00 ___ \$200.00
Associate Members: All other doctoral degrees including D.D.S., D.M.D., plus C.R.N.A., P.A., N.P., and C.N.M. Retired (0 Hours per Week)	___ \$225.00 ___ \$100.00
Affiliate Members: Medical Students (4 Year Fee) Medical Students (1 Year Fee) Nurses and Allied Health Professionals Retired (0 Hours per Week) Clergy and Religious Seminarians Friends and Supporters Non-Catholic Physicians	___ \$100.00 ___ \$35.00 ___ \$150.00 ___ \$100.00 ___ \$50.00 ___ No Charge ___ \$150.00 ___ \$200.00



Payment Method: CHECK (Check # _____)
 Make check payable to Catholic Medical Association

CREDIT CARD: Visa MC AMEX Discover

Credit Card Number:

Expiration Date:

I authorize \$ _____ to be charged to this credit card.

Billing address, if different from mailing address below:

Signature (for credit card payments):

Date:

For security reasons, do not send credit card info via e-mail.

Please print clearly

Name: _____

E-mail: _____

Mailing preference: Home Office

Local CMA Guild: _____ None

Organization (if Office):

Degree: _____

Address: _____

Primary Specialty: _____

Other Specialties: _____

City: _____

Gender: Male Female Year of Birth: _____

Active or Retired Military: Yes No

Permanent Deacon: Yes No

State: _____ Zip Code/Postal Code: _____

Medical School Attended: _____

Year of Graduation: _____

Country (if not U.S.A.): _____

Telephone: Home Office Cell

How did you hear about the CMA? _____

(_____) _____