



CATHOLIC MEDICAL ASSOCIATION

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

2022 New Member Application

Membership dues stretch from January-December and should be paid by March 31st to keep membership current. 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. Renew online www.cathmed.org/membership

Membership Categories	Dues (Check or Credit Card)
Active Physicians (M.D., D.O.)	___ \$425.00
First Year in Practice	___ \$200.00
Second Year in Practice	___ \$300.00
Semi-Retired (<20 Hours per Week)	___ \$175.00
Retired (0 Hours per Week)	___ \$100.00
Residents or Fellows	___ \$50.00
Clergy or Religious who are Physicians	___ \$75.00
Uniformed Service (Active Duty Physicians Only)	___ \$200.00
All other doctoral degrees including D.D.S., D.M.D., plus C.R.N.A., P.A., N.P., and C.N.M.	___ \$225.00
Retired (0 Hours per Week)	___ \$100.00
Medical Students	___ \$25.00
Student (Other): _____	___ \$25.00
Nurses	___ \$150.00
Retired (0 Hours per Week)	___ \$100.00
Clergy and Religious	___ \$50.00
Seminarians	___ No Charge
Friends and Supporters	___ \$150.00
Non-Catholic Physicians	___ \$200.00



Payment Method: CHECK (Check # _____) CREDIT CARD: Visa MC AMEX Discover
Make check payable to Catholic Medical Association, 550 Pinetown Rd., Suite 205, Fort Washington, PA 19034

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

Donations for CMA Development Funds:	
• Use my gift for the most urgent priorities.	\$ _____
• Medical Student and Resident Education	\$ _____
• Public Advocacy	\$ _____
• Evangelization	\$ _____

Please print clearly

Name: _____

Mailing preference: Home Office

Organization (if Office): _____

Address: _____

City: _____

State: _____ Zip Code/Postal Code: _____

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

Telephone: Home Office
 Cell(_____) _____

E-mail: _____

Local CMA Guild: _____ None

Active or Retired Military: Yes No

Medical School Attended: _____

Year of Graduation: _____

Catholic Physician Search: Yes No
 (By selecting Yes, you are giving consent to be included in the CMA's Catholic Physician Search tool on our website.)

Permanent Deacon: Yes No
 Pre-Med: Yes No