



CATHOLIC MEDICAL ASSOCIATION

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

2024 GIFT MEMBERSHIP

Membership dues cover the January-December period and should be paid by March 31 to keep membership current.

Membership benefits include: spiritual and professional support; subscription to peer-reviewed bioethics journal, The Linacre Quarterly; access to the online Members Only Community platform; educational opportunities and networking; email updates and action alerts; early bird registration discount for the Annual Educational Conference.

Name of the Person(s) Donating the Gift Membership:

Membership Categories	Dues
Active (M.D., D.O.)	\$447
First Year in Practice	\$210
Second Year in Practice	\$315
Semi-Retired (<20 hours per week)	\$184
Retired (0 hours per week)	\$105
Residents or Fellows	\$53
Clergy or Religious who are Physicians	\$80
Uniformed Service (Active Duty Only)	\$210
All other doctoral degrees, including D.D.S., D.M.D., plus C.R.N.A., P.A., N.P., and C.N.M.	\$237
Retired (0 hours per week)	\$105
Medical Students	\$26
Students (Other): _____	\$26
Nurses and Allied Health Professionals	\$158
Retired (0 hours per week)	\$105
Clergy and Religious	\$53
Seminarians	No Charge
Friends and Supporters	\$158

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: _____ CVV: _____

I authorize \$ _____ to be charged to this credit card. Billing Address (if different from address below)

Signature (for credit card payments): _____ Date: _____

Gift Membership for:

Name: _____ Degree: _____

Preferred Address: _____ Primary Specialty: _____

Other Specialty: _____

City: _____ Board Certified in: _____

State: _____

Zip: _____ Gender: Male Female

Country: _____ Active or Retired Military: Yes No

Permanent Deacon: Yes No

Mobile Telephone: _____

Business Telephone: _____ Pre-Med: Yes No

Home Telephone: _____ Medical School Attending/Attended: _____

Year of Graduation: _____

Local CMA Guild: _____ Local CMA Student Chapter: _____

Send me the Catholic Physician Search Registration Form: Yes