



APPLICATION FOR MEMBERSHIP

Membership Category: Regular _____ Associate (Physician-in-Training) _____ Honorary _____

Name (Last, First, M.I., Degree): _____

Date of Birth: _____

Office #1 Address: _____

Office #2 Address: _____

City, State, Zip: _____

City, State, Zip: _____

Area Code, Phone #: _____

Area Code, Phone #: _____

Email Address: _____

Spouse's Name: _____

Residence Address: _____

Area Code, Phone #: _____ Fax # (work/home): _____

Spouse's Email Address: _____

Medical Education and Post Graduate Training

Medical School: _____

Graduation Year: _____

Residency (Location): _____

Completion Year: _____

Specialty: _____

Fellowship (Location): _____

Completion Year: _____

Specialty: _____

Applicant's Signature: _____

Date: _____

Please send the complete application and first year's membership dues (Regular \$75.00, Associate \$35.00, and Honorary-free) made payable to JAMA to the Treasurer, Alan Yamada, M.D. (624 W. Duarte Rd., #203, Arcadia, CA 91007) or the Membership Chairperson, John Mayeno, M.D. (Kaiser Permanente, 13652 Cantara Street, Panorama City, CA 91402). Some of the information in the application will be included in the JAMA Directory.

OFFICE USE ONLY

Amount of dues received: _____ Date received: _____ Date posted: _____
Directory information submitted: _____