Japanese American Medical Association

APPLICATION FOR MEMBERSHIP

NAME (Last, First, MI, Degree): _____

DATE OF BIRTH: _____

OFFICE ADDRESS: _____

CITY, STATE, ZIP: _____

EMAIL ADDRESS: _____

RESIDENCE ADDRESS: _____

CITY, STATE, ZIP: _____

AREA CODE & PHONE NUMBER: _____

SPOUSE'S NAME: _____

Do you speak fluent Japanese? _____

MEDICAL EDUCATION & POSTGRADUATE TRAINING

MEDICAL SCHOOL: _____ Graduation year: _____

RESIDENCY(location): _____ Completion year: _____

SPECIALTY/SUBSPECIALTY: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

Please send the application & member dues of $100 check, made payable to JAMA, mailed to treasurer:
Alan Yamada, MD, 624 W. Duarte Road, #203, Arcadia, CA 91007.
Your name, address, phone#, email & spouse's name will be stored in our distribution list.

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