



2011 Membership Application

**GUAM MEDICAL
ASSOCIATION**

Name: _____
First Middle Initial Last

Yes.

I accept your invitation for a full-year membership in the Guam Medical Association.

Office Address: _____

Phone: Home Office Fax

Cell/Pager Email

Mailing Address: _____

ACTIVE Member for those with Degrees of MD or DO. \$250.00 CASH _____ CHECK _____

MEDICAL SCHOOL: _____

RESIDENCY: _____

SPECIALTY: _____

BOARD CERTIFICATION: _____
(If Certified)

ASSOCIATE Member for those with allied health degrees. 200.00 CASH _____ CHECK _____

ALLIED HEALTH SCHOOL: _____

Applying for GMA membership: Membership is contingent upon the Guam Medical Association's (GMA) acceptance of the membership application. Active member has voting privileges and is consistent with membership degrees of MD or DO to be a full member of the American Medical Association. Associate member has no voting privileges but are welcome to meetings and functions. The endorsement, deposit or negotiation of an applicant's check does not guarantee admission into or acceptance of membership by the GMA.

Applicant Signature: _____ **Date:** _____

*You may fax completed application to 648-2220 or email at guammedicalassociation@gmail.com