



# Philippine Medical Association of Southern California

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Name:	
Title:	
Company:	
Address:	
Office Tel No.	
Office Fax:	
Email:	
Medical Specialty:	
Medical School:	
Year of Graduation:	
Mailing Address:	
Spouse:	
Children:	

Regular Membership \$50/year  
Lifetime Membership \$300 one-time payment

Check One

\_\_\_\_\_ New Member

\_\_\_\_\_ Renewal

Total Amount Enclosed \$ \_\_\_\_\_

Please make check payable to PMASC and mail application:

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Attn:

12444 E. Washington Blvd

Whittier, CA 90602

Date: \_\_\_\_\_