Philippine Medical Association of Southern California

MEMBERSHIP APPLICATION FORM

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:

PMASC Treasurer
Attn:
12444 E. Washington Blvd
Whittier, CA 90602

Date: _____