

Thank you for your interest in joining CMA and your county medical society!

To begin processing your membership, please fill out the information requested on the following application. When you are sure all information is correct, print out the document, sign and either fax (or mail) the completed application to your county medical society (see the information listed below).

Your application must be processed and approved by your local society. If you have any questions, the contact information listed below should be able to assist you.

North Valley Medical Association
1670 Market St., Ste. 118
Redding 96001
Trudy Tavares, CPA, Med Exec.
E-Mail: ttavares@nystromcpa.com
Debbie K Schoenthaler, Secretary
Email: debnvma@sbcglobal.net

North Valley Medical Association

APPLICATION FOR MEMBERSHIP



Please type or print in black ink - fill in all blanks. Mandatory fields are **RED** underlined.
 If more than one office, please list additional office address on a separate sheet of paper.
 A California Participating Physician Application may be substituted for this membership application.

Date Received: _____

Name: (As shown on license) **Last** **First** **Middle** **Other Name Used, If Any**

Birthdate required **Place of Birth**(optional) **Ethnicity**(optional) **Gender**(optional) **Social Security #**

Name of Corporation/Practice: _____ **Group Affiliation:** _____

Primary Office: **Street Address** **City** **ZIP** **Telephone #** **FAX #** **e-mail #**

Residence: **Street Address** **City** **ZIP** **Telephone #** **FAX #**

SEND MAIL TO: **Office** **Home** **Other Address:**

California License # **Date Issued** **Date Expires** **Other State Licenses (State-Date Issued)**

Has your medical license in California or any other state ever been limited, revoked, suspended, or placed on a probationary status - or is such action pending? **Yes** **No** (If Yes, please provide details on a separate sheet of paper and attach to this application)

Medical School **Location** **Check Degree** **Date**
 MD or **DO**

Internships: **Institution** **Address** **State** **Dept.** **Dates**

Residencies: **Institution** **Address** **State** **Dept.** **Dates**

Primary Specialty **Secondary Specialty** **Special Interests**

American Board Certification(s)/Date(s)

Medical Society Memberships: **Organizations/Dates**

Please select/check the Practice Arrangement/Mode of Practice that best describes your practice:

Solo/Small (1-4 phys. grp/corp) **Medium (5-150 phys. grp/corp)** **Large (150-1,000 phys. grp/corp)** **Very Large (1,000+)**
 Academic Practic **Hospital-Based Practice** **Government-Employed Physician** **Fully Retired**
 Administrative Medicine

The undersigned agrees in case of election that membership in this Component Medical Society shall be conditional upon compliance with the Constitution & Bylaws and Principles of Medical Ethics of the AMA, the CMA and the Component Medical Society. The undersigned further agrees that he/she will recognize the authorized Officers of said Society & Associations as the proper and sole authorities to interpret any doubtful point in professional conduct and will at all times abide by and be governed by their interpretations.

"I hereby affirm that the information provided on this Application for Membership, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application and/or termination of my membership should I be elected a member of said Society and Association. I understand and agree that acceptance of this application, application fees and/or dues does not constitute approval or acceptance of my membership, and grants me no rights or privileges of membership until such time as I receive notice of approval of my application and my acceptance letter.

Yes, this application includes membership with the American Medical Association.

APPLICANT'S SIGNATURE: _____ **DATE:** _____