



Date Received by VCMA _____

*"ADVOCATES FOR PATIENTS, PHYSICIANS
AND HIGH QUALITY MEDICAL CARE"*

MEMBERSHIP APPLICATION
Ventura County Medical Association (VCMA)
California Medical Association (CMA)

Name (as shown on CA License)

Location Address

Office Telephone Number Office Fax Number E-Mail/Website Address

Home Address: **NOTE:** Please put a check mark by the address you'd like us to use for VCMA/CMA correspondence and publications.

Home Telephone Number Spouse's Name Social Security Number

Birthdate Place of Birth

Specialty Subspecialty CA M.D. or D.O. License Number

ABMS Board Certification including year of certification and recertification; also subspecialty certification and year

Medical School 19_____
Date of M.D. or D.O. (circle one)

Internship 19_____
to 19_____

Residency 19_____
to 19_____

Peer Sponsor (must be an active VCMA member) VCMA can assist if unknown.

Previous California Medical Association (CMA) Active member? _____
yes no

If yes, member of which county medical society? _____

I am currently a member of AMA.

The foregoing is true and complete, and I endorse the Principles of Medical Ethics of VCMA, CMA, and AMA.

Signature Date

Mail completed application, dues statement and payment to:
VCMA, 601 East Daily Drive, Suite 129, Camarillo, CA 93010
Telephone: 805/484-6822 Fax: 805/484-6812