Columbus Medical Association

Columbus Medical Association Alliance
431 East Broad St. Suite 300
Columbus, Ohio 43215

Application and Annual Dues Statement

Name:_____
Last First
Address: _____

City:_____State_____Zip_____

Telephone:_____Fax_____Cell_____

Email:_____

Spouse's Name:_____

DUES:

[} National, State & Local Dues ($90.00)
[ ] State & Local ($50.00)
[ ] Widow/Retired ($20.00)
[ ] Resident Physician & Medical Student Spouse ($12.00)

Donations to Philanthropy Projects:

Adopt a Family	$_____
AMA Foundation	$_____
Doctor's Day	$_____
Medical Student Scholarship	$_____
Nursing Scholarship	$_____
Teen Hotline Card	$_____
Undesignated	$_____

Donations	$_____
Dues	$_____
Amount Enclosed	$_____

[ ] My dues will be paid with my spouse's CMA dues statement.

Make checks payable to: Columbus Medical Association Alliance

Return to: Sandra Gahman
526 Haymore Ave. N. Worthington, OH 43085-2445