



MEMBERSHIP APPLICATION

Welcome to the SCMA Alliance

As a Physician, Resident Physician, Medical Student, Fellow or Spouse/Partner of a physician, this organization is *exclusively yours* to join. The Alliance brings those with similar backgrounds and shared experiences together. Being a member is your *social connection* to the unified yet diverse face of medical families in our community.

The Alliance gives you the opportunity to *connect in a manner that is most meaningful to you* and open the doors to:
Friendships & a Support System | Business Networking | Social Activities for Adults & Children
Leadership Knowledge & Personal Development | Education & Advocacy for Healthier Communities

It's Easy to Sign Up!

www.scmaa.org

_____ Name	_____ Spouse/Partner's Name
_____ Address	_____ Spouse's Medical Specialty
_____ City/State/Zip	_____ Your Profession/Affiliations
_____ Phone (H)	_____ Phone (W)
_____ Phone (C)	_____ Email address

Check one Alliance Membership category:

- ___ **Standard Member:** Physician or spouse/partner of a physician, or divorced spouse of a physician who has not remarried (includes County & State Dues) **\$ 65.00**
- ___ **Sustaining Member:** Spouse of a part-time, retired or deceased physician (includes County & State Dues) **\$ 50.00**
- ___ **Medical Student/Resident Spouse/Fellow:** (includes County & State Dues) **\$ 15.00**
 1st year *free*; subsequent years:
- Optional:* **American Medical Association Alliance Member** (includes National Dues): **\$ 50.00**

PAYMENT

- ___ Check (payable to SCMA-Alliance)
- ___ Please charge my membership to: (circle one) Visa or MasterCard

TOTAL: _____

Signature *Card #* *3 digit code* *Exp date*

ALLIANCE INVOLVEMENT

- ___ *Yes, I would like to become more involved with the Alliance!* Best way to contact me and when: _____
- My interests include _____, my special skills include _____.

Send completed application (and check) to: SCMAA Membership, P. O. Box 1388, Santa Rosa, CA 95402