MEMBERSHIP APPLICATION

ARKANSAS MEDICAL, DENTAL & PHARMACEUTICAL ASSOCIATION, INC.

MEMBERSHIP CATEGORY (Check one) **Date:** _____

❑ **Member ($325.00)** ❑ **Associate ($165.00)** ❑ **Resident ($50.00)** ❑ **Medical, Dental or Pharmacy Students (Free)**

MEMBER PROFILE (Please print or type)

_____ / _____ / _____ / _____

FIRST NAME | MIDDLE INITIAL | LAST NAME | SUFFIX

Date of Birth: _____/ _____/ _____ **Gender:** ❑ **Male** ❑ **Female** **Place of Birth:** _____

Marital Status: **Spouse Name:** **Is spouse a physician:** ❑ **Yes** ❑ **No**

Do you prefer to receive mail at ☐ Home or ☐ Office

BUSINESS CONTACT INFORMATION

❑ **Primary Office** **Practice/Group Name:** _____

Street/P.O. Box: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____

Email Address: _____ **Web site Address:** _____

❑ **Office #2** **Practice/Group Name:** _____

Street/P.O. Box: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____

PERSONAL CONTACT INFORMATION

❑ **Home Address** **Street/P.O. Box:** _____

City : _____

Telephone: _____ **Cell Phone:** _____

Email Address: _____

EDUCATION/PROFESSIONAL PRACTICE INFORMATION

Current Degree(s): ❑ **DO** ❑ **DPM** ❑ **DMD** ❑ **MD** ❑ **PhD** ❑ **DDS** ❑ **DCM** ❑ **PharmD** ❑ **Other(s) (Specify)** _____

PRACTICE DESCRIPTION: ❑ **Solo** ❑ **Group #**_____ ❑ **Hospital** ❑ **Partnership** ❑ **Other** _____

Primary Specialty: _____ **Secondary Specialty**_____

Board Certified: ❑ **Yes** ❑ **No**

State(s) in which Professionally Licensed/Professional School Attended: _____

Practice/Group Contact: _____

MEMBERSHIP

PAYMENT OPTIONS: ❑ **Check** ❑ **Visa** ❑ **Master Card** ❑ **American Express** ❑ **Discover Card**

Account #: _____ **Expiration Date:** _____

Name As It Appears on Card: _____ **CV V Code**_____

Billing Address: _____ **Zip Code** _____

Cardholder's Signature: _____

APPLICANT SIGNATURE

I hereby attest to the accuracy of the foregoing information and apply for membership in the Arkansas Medical, Dental and Pharmaceutical Association.

Signed: _____ Date: _____

Return application along with your payment to: AMDPA ♦ P. O. Box 55104 ♦ Little Rock, AR 72215-5104