MEMBERSHIP APPLICATION

SOUTHERN ILLINOIS MEDICAL ASSOCIATION

(Please PRINT or TYPE)

NAME_____DEGREE_____

HOME ADDRESS_____

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ZIP CODE_____

HOME PHONE NUMBER____(_____)_____

OFFICE ADDRESS_____

_____

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ZIP CODE_____

OFFICE PHONE NUMBER__(_____)_____

SPECIALTY_____

E-MAIL ADDRESS_____

DO YOU PREFER TO HAVE LETTERS, PROGRAMS, AND DUES STATEMENTS MAILED TO:

YOUR HOME____OR OFFICE____ADDRESS? (PLEASE CHECK ONE)

ANNUAL DUES ARE $50/year for Physicians, Physician Assistants, Nurse Midwives, & Advance Practice Nurses.

MAIL APPLICATION AND CHECK TO:

Southern Illinois Medical Association

Kathy D. Swafford, M.D.-Executive Secretary-Treasurer

1680 Lick Creek Rd.

Anna, IL 62906

SIGNATURE_____

DATE_____