Clark County Medical Society Alliance
Membership Application

First Name: _____ Last Name: _____

Address: _____

Phone: _____ Fax: _____ Work: _____ Cell: _____

E-mail:_____ Occupation/Educational Background: _____

Spouse's Name: _____ Spouse's Specialty: _____

Spouse's Practice/Group Name: _____ Spouse's Practice/Group Phone Number: _____

Please check one: Spouse: MD _____ or DO_____

Type of Spouse Membership: □ Regular **$85.00** □ Medical Student **$20.00** □ Associate Member: Resident/Widow/Retired/Military **$20.00**

I have an interest in the following special interest groups:
□ Book Club □ Toddler Play Group □ Cooking Club □ Dining Group
□ Fitness/Nutrition □ _____ (Other Suggestion)

Are you interested in leading/starting a Special Interest Group? Yes □ No □ What type? _____

I would like information on the following committees:
□ Legislative □ Fashion Show □ Community Health/Outreach □ Holiday Scholarship Project □ Medical Office Practice Managers
□ American Medical Association Alliance (AMAA) Western Regional Conference Planning Committee (Conference in Jan. 2018)
□Opiate Epidemic-Health Initiative □ _____(Other Suggestion)

Unless you otherwise direct in writing, the information provided herein, will be placed in the Membership Directory, provided to Members ONLY. I agree that CCMSA may use photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature_____

Printed name_____

Date: _____

If you have any questions regarding Membership, Sponsoring the Membership Directory, or other Alliance concerns, please contact 1st Vice President Membership: Ginger Allen –gingerlallen@gmail.com or 702-767-1735

Method of Payment **DEADLINE October 31, 2016** **Website (http://www.ccmsa-lv.org/)** **Credit Card or Check**

VISA Master Card

Credit card # _____ Exp. Date _____ (MM/YY) Security # _____

Credit Card Signature: _____

Name as it appears on the card:_____
Billing address including zip code, if different from above Home Address:
_____

_____

Make checks payable to: Clark County Medical Society Alliance or CCMSA
Check Amount $_____ Check # _____

Mail to: Clark County Medical Society Alliance
2590 E. Russell Road, Las Vegas, NV 89120 Telephone 702.739.9989 Fax 702.739.6345
"Spouses of Physicians Building a Healthy Southern Nevada"