



Dade County Medical Association
 1501 NW North River Drive Miami, FL 33125
 Tel: (305) 324-8717 Fax: (305) 325-1316
"Promoting Quality Medical Care since 1903."

**Aventura Hospital and
 Medical Center
 NEW MEMBER
 PROMOTION ONLY
 2012 and 2013 Dues Years
 PAY ONLY - \$150**

**LET YOUR VOICE BE HEARD!
 JOIN THE DADE COUNTY MEDICAL ASSOCIATION!**

We take care of you...
 So you can take care of your patients.
 But, we need your help.

The DCMA is the largest medical association in Miami Dade County representing you and your patients. We cannot be effective unless all physicians join.

Membership... You Can Count on the Benefits!
 Advocacy in the Florida Legislature
 Intervention with Government Agencies
 Grass Roots Lobbying here and in Tallahassee
 Discounts on All Insurance Needs
 and much more. For more information go to www.miamimed.com

Membership Application & Qualification

Name (please print) _____

Office Address _____

City _____ State _____ Zip _____ Physician Referral Program Yes No

() _____ () _____ | |

Office Telephone _____ Office Fax _____ Date of Birth (required) _____

Email address _____ Specialty _____

Credit Card # _____ Exp. Date _____ Billing Zip Code _____ Dues: \$150.00

Please make check payable to: Dade County Medical Association 1501 NW North River Drive, Miami, FL 33125

Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign and date. If you answer yes to any of these questions, please attach full information.

Yes No

- Have you ever been convicted of fraud or a felony?
 - Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.
 - Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?
- I am aware that the information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

Signature (required) _____ Date _____