



2009 Alliance Membership Application

- Dade CMAA - \$20 • FMAA - \$40 • AMAA - \$40

Name _____

Address _____

City/St/Zip _____

Occupation _____

Special interests/comments _____

Gender _____ Date of Birth _____

Physician Spouse's full name _____

Preferred Contact:

Home _____

Business _____

Cell _____

E-mail _____

Alliance Dues: DCMAA, \$20
FMAA, \$40
AMAA, \$40

Total Dues Paid: \$ _____

Payment by:

Credit Card
___ VISA ___ MASTERCARD ___ AMEX

Card# _____ Exp. _____

Name on Card _____

Check (check included)

Mail or Fax to:

Florida Medical Association Alliance
Attn: Allison Finley, Executive Director
P.O. Box 10269, Tallahassee, FL 32302
Fax: 850.513.9477