



**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."*

1<sup>st</sup> Year Membership  
 (2012 Dues Year)  
 Courtesy Discount  
 Compliments of  
 Mount Sinai Medical Staff

**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  
 Grass Roots Lobbying here and in Tallahassee  
 Intervention with Government Agencies  
 Discounts on All Insurance Needs  
 and much more. For more information go to [www.miamimed.com](http://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 1<sup>st</sup> Year Dues: \$70.00

**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 \_\_\_\_\_