DADE COUNTY MEDICAL ASSOCIATION
1501 NW NORTH RIVER DRIVE - 2ND FLOOR
MIAMI, FL 33125
Phone: (305) 324-8717 - Fax: (305) 325-1316
E-Mail: dcma@miamimed.com - Website: www.MiamiMed.com

MEMBERSHIP APPLICATION PHYSICIAN ASSISTANTS

APPLICANT INFORMATION

Name (First Middle Last)		
Degree/ Certificate Designation (after name):		
Home Mailing Address 1:		
Home Mailing Address 2:		
City:	State:	ZIP Code:
Phone Number:	Home/ Personal Fax:	
Preferred E-Mail:	Secondary E-Mail:	
Gender: Male/ Female *(Please circle)*	Date of Birth:	Languages Spoken:

PROFESSIONAL INFORMATION

Florida PA License Number:	NCCPA Certification Number:
Are you a member of the FAPA? Yes / No *(Please circle)*	Are you a member of AAPA? Yes / No *(Please circle)*
Are you a member of any PA specialty organization? Yes / No *(Please circle)*	If so, which?
PA School Attended:	Year of Graduation:

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PRACTICE INFORMATION

Practice Name:		
Practice Address 1:		
Practice Address 2:		
City:	State:	ZIP Code:
Specialty of Practice:	Type of Practice: *(Please circle)* Solo / Group / Academic / Government / Hospital	
Number of Physicians in Practice:	Official Supervising Physician:	
Practice Main Phone:	Direct Line:	Cell Phone:
Pager:	Business Fax:	

MEMBERSHIP INFORMATION

Would you like to be listed in our Online Membership Directory? (when available) Yes/ No *(Please circle)*	
Would you like to receive industry related faxes from us? Yes / No *(Please circle)*	Preferred Fax number:
Would you like to receive industry related E-mails from us? Yes/ No *(Please circle)*	Preferred E-mail address:
If the answer was No to the above questions, where should postal mailings be directed? Home or Practice *(Please circle)*	

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.

(Please circle)

Yes/ No Have you ever been convicted of fraud or a felony?

Yes/ No 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.

Yes/ No 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: _______________

Name of Sponsoring Physician: ____ (must be a DCMA member).

PA Dues are $100.00. Please mail application and *check to DCMA.
*Make checks payable to Dade County Medical Association.
1501 NW North River Drive; 2nd Flr.; Miami, FL 33125.

Thank you for joining the DCMA! We look forward to working with you!