



PAN AMERICAN MEDICAL  
ASSOCIATION OF CENTRAL FLORIDA, INC.  
PO Box 536488  
Orlando, Florida 32853-6488

## APPLICATION FOR MEMBERSHIP

Date \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Country \_\_\_\_\_

Office Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Home Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Mailing Address  Home  Office  Other \_\_\_\_\_

Specialty \_\_\_\_\_

Staff Privileges \_\_\_\_\_

Medical School \_\_\_\_\_ Year Graduated \_\_\_\_\_

Years in Central Florida \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Birthplace \_\_\_\_\_

Number of Children \_\_\_\_\_

List societies, awards, professional recognitions \_\_\_\_\_

Hobbies or special interests \_\_\_\_\_

Sponsoring member, \_\_\_\_\_

### **Please include your Curriculum Vitae**

Please return completed application with \$250 payment (\$100 one-time application fee and \$150 annual dues.)

DO NOT write below this line

Approved  Not Approved

Date \_\_\_\_\_ Signature \_\_\_\_\_

### **CREDIT CARD INFORMATION FOR MEMBERS AND GUESTS**

**Make checks payable to Pam American Association or credit cards - VISA, MC, AMEX, Discover**

Check # \_\_\_\_\_  Visa  MC  AMEX  Discover

Card # \_\_\_\_\_  Expiration (MO/YR) \_\_\_\_\_

Signature \_\_\_\_\_