Central Coast Medical Association

Application for Membership

apply online at www.cmanet.org/join

Name as shown on medical license			
First	Middle	Last	Suffix
Other name used, if any			
Birthdate (mm/dd/yyyy)	Social Security #	Gender ☐ male ☐female	
Applicant type			
I am a ☐ student ☐ resident ☐ physician	I work ☐ 20 hours or more per week ☐ less than 20 hours per week	Are you a government employee? ☐ no ☐ yes	
Mode of Practice ☐ Solo/Small (1-4 physicians) ☐ Medium (5-150 physicians) ☐ Large (150-1,000 physicians) ☐ Very large (1,000+) ☐ Administrative medicine ☐ Academic practice ☐ Hospital-based ☐Government-employed ☐Fully retired			
California Medical License #	Date Issued	First Year of Practice	
Specialties			
Primary	Secondary	Interests	
Medical school			
Institution	Location	Graduation Year	Degree ☐ MD ☐ DO
Residency program			
Type ☐ Intern ☐ Residency ☐ Fellowship ☐ Graduate ☐ Post graduate	Institution	Location	Graduation Year
Type ☐ Intern ☐ Residency ☐ Fellowship ☐ Graduate ☐ Post graduate	Institution	Location	Graduation Year
Type ☐ Intern ☐ Residency ☐ Fellowship ☐ Graduate ☐ Post graduate	Institution	Location	Graduation Year
Medical practice			
Name of Corporation/Practice	Group Affiliation		
Business Website			

Central Coast Medical Association

Application for Membership

apply online at www.cmanet.org/join

Primary office location			
Street	City	State	Zip
Secondary office location			
Street	City	State	Zip
Office mailing address, if different from above			
Street	City	State	Zip
Home address			
Street	City	State	Zip

Send mail to ☐primary office location ☐ secondary office location ☐ office mailing address ☐ home address

Email address	
Business	Personal

Send email to ☐ business ☐ personal

Contact numbers		
Primary Office Phone	Secondary Office Phone	Cell Phone
Primary Office Fax	Secondary Office Fax	Home Phone

Office manager		
Name	Phone	Email

Attestation

By submitting this application, I hereby affirm that the information provided on this Application for Membership, and any addenda thereto is true, correct, and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application and /or termination of my membership. I understand and agree that acceptance of this application, application fees and/or dues does not constitute approval or acceptance of my membership, and grants me no rights or privileges of membership until such time as I receive notice of approval of my application and my acceptance letter.

Signature	Date

Return completed application to

Central Coast Medical Association
5350 Hollister Avenue, Suite A4, Santa Barbara, CA 93111
T: 805.683.5333 F: 805.364.5431 E: sbcms@sbmed.org

Rev 2014-04-22