

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



Central Coast Medical Association

Application for Membership

apply online at www.cmanet.org/join



<i>Primary office location</i>			
Street	City	State	Zip
<i>Secondary office location</i>			
Street	City	State	Zip
<i>Office mailing address, if different from above</i>			
Street	City	State	Zip
<i>Home address</i>			
Street	City	State	Zip
Send mail to <input type="checkbox"/> primary office location <input type="checkbox"/> secondary office location <input type="checkbox"/> office mailing address <input type="checkbox"/> home address			
<i>Email address</i>			
Business		Personal	
Send email to <input type="checkbox"/> business <input type="checkbox"/> personal			
<i>Contact numbers</i>			
Primary Office Phone	Secondary Office Phone	Cell Phone	
Primary Office Fax	Secondary Office Fax	Home Phone	
<i>Office manager</i>			
Name	Phone	Email	
<i>Attestation</i>			
<p>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.</p> <p>By typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.</p>			
Signature			Date

Return completed application to
Central Coast Medical Association
 100 N Hope Ave, Ste 14, Santa Barbara, CA 93110
 T: 805.683.5333 F: 805.364.5431 E: sbcms@sbmed.org