



Name: _____ Degree (s): _____ D.O.B. _____

Primary Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Email: _____

Licensed States and Number: _____ Gender: M F

Specialty: _____

Reason for Joining: _____

Individual Type:

- Chiropractor
- Diagnostic Medical Physics
- Nurse
- PhD
- Pharmacist
- Physician Assistant
- Podiatrist
- Psychologist
- Social Worker
- Other: _____

Interest Categories:

- Bioethics & Medical Education
- Emergency & Disaster Medicine
- Medicine & Medical Subspecialties
- Mental Health
- Public Health & Environment Medicine
- Quality Care, Patient Safety, & Best Practices
- Surgery and Surgical Subspecialties
- Women's & Children Health

Other: _____

Communication Preference Opt-In

I Authorize SMA to contact me through the following channels

- Text (Urgent Updates, New CME and SMJ Updates)
- Email (Newsletters, Invoices, Promotions)
- Phone
- Mail
- Fax

SMA Allied Health Professional Membership (One Year) \$200.00

- Check (Made payable to SMA)
- Visa
- Mastercard
- Discover
- AMEX

Payment Information:

Name as it appears on card: _____ Signature: _____

Card Number: _____ Expiration date: _____ Security Code: _____



Billing Address is the same as the Primary Address listed above.

Billing Address: _____ City: _____ State: _____ Zip: _____

Billing Phone: _____ Billing Email: _____

Joining Members Please Note!

You have 31 days from your joining date to take advantage of the \$150,000 of Term Life and \$1000 Long-Term Disability benefits without evidence of insurability as long as you are under the age of 65 and working full time.

Check here if you would like to apply.