SMA
SOUTHERN MEDICAL ASSOCIATION

GROUP MEMBERSHIP APPLICATION

Membership in an association must provide both flexibility and value. To this end, SMA offers a "Group Membership". Group membership considers how much you and your practice participate in all of our business programs, then discounts your membership dues accordingly. Members who participate in 2 or more financials services or practice management programs will likely qualify for a group discount.
Below are examples of dues rates reductions.

Membership Type	1-5 Physicians	6-10 Physicians	10+ Physicians
Physician/DO's	$250 Annually	$200 Annually	$150 Annually
Allied Health Professionals	$100 Annually	$75 Annually	$50 Annually
Healthcare Management	$100 Annually	$75 Annually	$50 Annually
Resident Physicians	$50 Annually	$50 Annually	$50 Annually

SMA Group Membership (One Year)
□ 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:____

Reason for Joining:____

Physician Application:

Name: ____Degree (s)_____________D.O.B._______________

Primary Address:____

City:____State:_____________Zip:______________________

Primary Phone:______________________________Email:____

License Info: State: ___________________ License # ___________________ Board: ______________________

Specialty:____ Gender: □ M □ F

Practice Name:____

Medical School Attended:____ Graduation Year: ______________

Residency Program: ____ Year Completed: _______________

Reason for Joining:____

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)

□ Fax #__________________________

□ Cell # _________________________

□ Mail

□ Phone

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.

Healthcare Management Application:

Name: ____Degree (s)_____________D.O.B.______________

Practice Name:____

Primary Address:____

City:____State:_____________Zip:_____________________

Primary Phone:______________________________Email:____

Specialty:____ Gender: □ M □ F

Individual Type: □ Executive □ Management

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□ Cell # _________________________
□ Mail
□ Phone

RESIDENT APPLICATION

Name: ____Degree (s)_____________D.O.B._______________

Primary Address:____

City:____State:_______________Zip:____________________

Primary Phone:_______________________________Email:____

Specialty:____ Gender: ☐ M ☐ F

Medical School Attended:____ Graduation Year: _______________

Residency Program: ____ End of Residency Date: _______________

Residency Director's Name: ____

License Info: State: ____________________ License # ____________________ Board: ______________________

Reason for Joining:____

Communication Preference Opt-In

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☐ Text (Urgent Updates, New CME and SMJ Updates)

☐ Email (Newsletters, Invoices, Promotions)

☐ Fax #___________________________

☐ Cell # __________________________

☐ Mail

☐ Phone

Joining Members Please Note!

As a new resident member, you would qualify for up to $50,000 of Group Term Life Insurance at no additional charge.

☐ Check here if you would like to apply.

ALLIED HEALTH PROFESSIONAL

Name: ____Degree (s)_____________D.O.B.______________

Primary Address:____

City:____State:_________________Zip:________________________

Primary Phone:________________________________Email:____

License Info: State: ____ License # ____________________________

Specialty:____ Gender: □ M □ F

Practice Name:____

Reason for Joining:____

Communication Preference Opt-In

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□ Email (Newsletters, Invoices, Promotions)

□ Fax #__________________________

□ Cell # _________________________

□ Mail

□ Phone