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 financial 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) □ AMEX □ VISA □ MASTERCARD □ DISCOVER

Payment Information:

Name as it appears on card:_____Signature:_____

Address:_____

City:_____State:_____Zip code:_____

Phone:_____Email:_____

Card Number: _____Expiration date:_____Security Code:____

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

Billing Address:_____

City:_____State:_____Zip code:_____

Billing Phone:_____Billing Email:_____

Reason for Joining:_____

GROUP MEMBERSHIP APPLICATION

Physician Application

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

Primary Address Information:

Address:_____

City:_____State:_____Zip code:_____

Phone:_____Email:_____

License Info:

State:_____License #:_____Board:_____

Specialty:_____Gender: □ M □ F

Practice/Hospital 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) Cell Phone Number:_____
□ Email (Newsletters, Invoices, Promotions
□ Mail
□ Fax Number:_____

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.

GROUP MEMBERSHIP APPLICATION

Resident Application

Name:_____Degree(s):_____D.O.B._____

Primary Address Information:

Address:_____

City:_____State:_____Zip code:_____

Phone:_____Email:_____

License Info:

State:_____License #:_____Board:_____

Specialty:_____Gender: □ M □ F

Medical School Attended:_____Graduation Year:_____

Residency Program:_____End of Residency Date:_____

Residency Program Director:_____

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) Cell Phone Number:_____
□ Email (Newsletters, Invoices, Promotions
□ Mail
□ Fax Number:_____

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.

GROUP MEMBERSHIP APPLICATION

Healthcare Management Application

Name:_____Degree(s):_____D.O.B._____

Practice/Hospital Name:_____

Practice Specialty:_____

Primary Address Information:

Address:_____

City:_____State:_____Zip code:_____

Phone:_____Email:_____

Gender: □ M □ F Individual Type: □ Executive □ Administrator □ Practice Manager

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) Cell Phone Number:_____
□ Email (Newsletters, Invoices, Promotions
□ Mail
□ Fax Number:_____

GROUP MEMBERSHIP APPLICATION

Allied Health Professional Application

Name:_____Degree(s):_____D.O.B._____

Primary Address Information:

Address:_____

City:_____State:_____Zip code:_____

Phone:_____Email:_____

License Info:

State:_____License #:_____Board:_____

Specialty:_____Gender: □ M □ F

Individual Type: □ Chiropractor □ Diagnostic Medical Physicists □ Nurse □ PhD □ Pharmacist

□ Physician Assistant □ Podiatrist □ Psychologist □ Social Worker

Practice/Hospital Name:_____

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) Cell Phone Number:_____
□ Email (Newsletters, Invoices, Promotions
□ Mail
□ Fax Number:_____