HISPANIC AMERICAN MEDICAL ASSOCIATION OF LA
P.O. Box 850868
New Orleans, LA 70185
(504)401-0284

PRACTICING PHYSICIANS	$150
RETIRED PHYSICIANS	$100
FELLOWS & RESIDENTS	$ 75
MEDICAL STUDENTS	$ 50

APPLICATION FOR MEMBERSHIP

NAME: ____ DATE: ______________________

HOME ADDRESS: ____

CITY, STATE, ZIP: ____

TELEPHONE: _______________________ E-MAIL: ____

OFFICE ADDRESS: ____

TELEPHONE: _____________________ CELL: _______________________ FAX: ________________

SPOUSE'S NAME_______________________OCCUPATION:_________________________________

MEDICAL EDUCATION

MEDICAL SCHOOL: __________________________ SPECIALTY: ____________________________

YEAR OF GRADUATION: _____________ SPECIAL INTEREST: ______________________________

INTERNSHIP: ____

RESIDENCY: ____

FELLOWSHIP: ____

FACULTY APPOINTMENT: ____

SPONSORED BY: 1. ____

2. ____

MAIN HOSPITAL AFFILIATION: ____

PLEASE SEND CHECK WITH APPLICATION