



Columbus Medical Association Allliance
1390 Dublin Rd., Columbus, Ohio 43215
Application and Annual Dues Statement

Name _____

Last

First

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ Cell _____

Email _____

Spouse Name _____

Dues: [☐] National, State, Local—\$100.00

[☐] State & Local 50.00

[☐] Widow/Retired 20.00

[☐] Resident Physician 12.50

& Medical Student

Donations to Philanthropy Projects

Adopt a Family \$ _____

Medical Scholarship \$ _____

Nursing Scholarship \$ _____

Doctor's day \$ _____

Teen Hotline Card \$ _____

Undesignated \$ _____

Dues _____

Donation total _____

Amount Enclosed _____

Make checks payable to Columbus Medical Association Alliance

Mail to: CMAA, Joyce Penn, 2800 Squire Ridge, Columbus, OH 43220-6201