NEW MEXICO
MEDICAL
SOCIETY

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MEMBERSHIP APPLICATION

State and County

$250 membership dues required with application

Name: (First) (Middle) (Last)

Home Address: (Street) (City) (Zip)

Home Phone: Cell Phone: Date of Birth:

Home Email:

Office Address: (Street) (Suite) (City) (Zip)

Practice Name: Office Phone: Work Email:

Preferred Mailing Address: Work ☐ Home ☐

Specialty: American Board Certified: Yes ☐ No ☐

Secondary Specialty: American Board Certified: Yes ☐ No ☐

Additional:

Medical School Graduated: Date Completed: (mm / dd / yyyy)

Internship Institution: Date Completed: (mm / dd / yyyy)

Residency: Date Completed: (mm / dd / yyyy)

Gender M/F ME# Year Licensed in NM:

Signed: Date:

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Date Received: _____ Amount: _____ Form of Payment: _____

OVFM: _____ Phys. Finder: _____ MSMEM: _____

NMMB Verification: _____ New Member Packet: _____ Newsletter / Add List: _____