Pennsylvania
MEDICAL SOCIETY®

777 EAST PARK DRIVE, PO BOX 8820 • HARRISBURG, PA 17105-8820

MEMBERSHIP APPLICATION/REQUEST FOR ADDITIONAL INFORMATION

PHYSICIAN NAME ____
FIRST MIDDLE LAST SUFFIX TITLE (MD/DO)

BUSINESS ADDRESS ____

____

HOME ADDRESS ____

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Please indicate which address you'd like us to use to communicate with you: ☐ HOME ☐ BUSINESS

LICENSE # ____

RESIDENCY YEAR END DATE ____

BIRTH DATE ____

BUSINESS PHONE ____

EMAIL ____

Please select your county affiliation: ____
(YOU MAY CHOOSE TO BE A MEMBER OF THE COUNTY IN WHICH YOU EITHER LIVE OR WORK.)

☐ Please bill me. I wish to become a member of the Pennsylvania Medical Society (PAMED) and my county medical society.
Please note that full PAMED dues are $395. Dues rates for county medical societies vary.* ***You may qualify for our introductory membership rate of $95—
Please call us at 855-PAMED4U (855-726-3348) for a quote or with questions.

☐ I would like to hear more about what the Pennsylvania Medical Society and my county medical society are doing. Please contact me at:

______________________ ______________________
PHONE EMAIL

RETURN THIS FORM USING THE ENVELOPE PROVIDED OR FAX US AT 717-558-7848.
PREFER TO JOIN ONLINE? VISIT WWW.PAMEDSOC.ORG/MEMBERSHIP.