TEXAS MEDICAL ASSOCIATION ALLIANCE

401 West 15th Street, Austin, Texas 78701

Dallas County Medical Society Alliance & Foundation Membership Application

Physician Name: _____ Physician Specialty: _____

Spouse Name: _____

Home address: _____

Home phone: _____ Cell phone(s): _____

Email(s):_____

Please notate preferred email for digital communication from DCMSAF.

2018 Dues:

Regular Members: DCMSAF, TMAA.....	**$100.00**	_____
Spouses of retired physicians: DCMSAF, TMAA.....	**$75.00**	_____
Widowed Members: DCMSAF, TMAA.....	**$35.00**	_____

Optional items

*Aldredge House Patron.....	$100.00	_____
*Edith Cavell Nursing Scholarship Fund.....	$50.00	_____
*Benefactors Endowment Fund	$50.00	_____
Printed & Mailed Newsletter Fee	$10.00	_____
TEXPAC	$55.00	_____

*Tax Deductible Item.

..... TOTAL: _____

Please make check payable to TMAA or complete the credit card authorization below.

Credit Card #: _____

Expiration date: _____ **Security Code:** _____

Name on Card: _____