



Dallas County Medical Society Alliance Foundation

**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:**

<b>Regular Members: DCMSAF, TMAA.....</b>	<b>\$100.00</b>	_____
<b>Spouses of retired physicians: DCMSAF, TMAA.....</b>	<b>\$75.00</b>	_____
<b>Widowed Members: DCMSAF, TMAA.....</b>	<b>\$35.00</b>	_____

**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:** \_\_\_\_\_