



## 2017 GATEWAY MEDICAL SOCIETY MEMBERSHIP APPLICATION

### MEMBERSHIP APPLICATION

Name:

Date of birth:

Cell Phone:

Phone:

Preferred Mailing address:

City:

State:

ZIP Code:

New Application  
*(Please circle)*

Update Application

Physicians \$200/yr \_\_\_\_\_  
 Associate Members \$50/yr \_\_\_\_\_  
 Residents/Fellows \$25/yr \_\_\_\_\_  
 Nurses \$25/yr \_\_\_\_\_

Email:

### BIOGRAPHICAL DATA

Education/Undergraduate:

Post-Graduate Training:

Degree

Specialty:

Type of Practice:

Academic Appointments:

### PRIMARY PRACTICE INFO (WILL BE LISTED ON WEBSITE)

Practice Name:

Address:

Phone:

City:

State:

ZIP Code:

Hospital Affiliation:

### SECONDARY LOCATION

Address:

City/State:

Zip Code:

Phone:

### PAYMENT METHOD

Enclosed is my check for my 2017 membership dues in the amount of \_\_\_\_\_ made payable to Gateway Medical Society

Credit Card Payment       Visa     Master Card     Discover     American Express

**\*Please complete the enclosed credit card payment form\***  
**Or Call 412-281-4086 to make a payment**