# 2025 GATEWAY MEDICAL SOCIETY MEMBERSHIP APPLICATION

| MEMBERSHIP APPLICATION | | |
|---|---|---|
| Name: | | |
| Date of birth: | Cell Phone: | Phone: |
| Preferred Mailing address: | | |
| City: | State: | ZIP Code: |
| New Application Update Application<br>*(Please circle)* | Physicians $200/yr _____<br>Associate Members $50/yr_____<br>Residents/Fellows $25/yr_____<br>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 2024 membership dues in the amount of _____made payable to Gateway Medical Society

[ ] Credit Card Payment [ ] Visa [ ] Master Card [ ] Discover [ ] American Express

*Please Call 412-281-4086 to make a credit card payment