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 *(Please circle)*	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 2020 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		