



Date Received by VCMA _____

"ADVOCATES FOR PATIENTS, PHYSICIANS AND HIGH QUALITY MEDICAL CARE"

MEMBERSHIP APPLICATION
Ventura County Medical Association (VCMA)
California Medical Association (CMA)

Name (as shown on CA License)

checkbox

Practice Address

Office Telephone Number Office Fax Number E-Mail/Website Address

checkbox

2nd Practice Address

2nd Office Telephone Number 2nd Office Fax Number E-Mail/Website Address

checkbox

Home Address

NOTE: Please put a check mark by the address you'd like us to use for VCMA/CMA correspondence and publications.

Home Telephone Number Home Fax Number Spouse's Name
Birthdate Place of Birth
Specialty Subspecialty CA M.D. or D.O. License Number

ABMS Board Certification including year of certification and recertification; also subspecialty certification and year

Medical School Date of M.D. or D.O. (circle one)
Internship to
Residency to

Peer Sponsor (must be an active VCMA member) VCMA can assist if unknown.

Previous California Medical Association (CMA) Active member? yes no

If yes, member of which county medical society Last Year of Membership

I am currently a member of AMA.

The foregoing is true and complete, and I endorse the Principles of Medical Ethics of VCMA, CMA, and AMA.

Signature

Date

Mail completed application, dues statement and payment to:
VCMA, 601 East Daily Drive, Suite 129, Camarillo, CA 93010
Telephone: 805/484-6822 Fax: 805/484-6812