Sindh Medical College Alumni Association of North America (SMCAANA)

Membership/Dues Form

Personal Information

Name:

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Address:

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Home Phone: ___________________________Office Phone__________________________

Cell Phone:____________________________ Fax:______________________________

Email Address:____

Year of Graduation:____

Specialty:____

Practice Type: __ Academic __ Private __ Research __ Other: ___________________________

Faculty Position: ________________________Institute:______________________________

Membership Type

_ Lifetime Membership Dues $250.00
_ Annual Membership Dues $25.00
_ Physician in Training *** Exempt

Method of Payment:

_ Cash
_ Check
_ Visa
_ MasterCard
_ American Express

Card Number: _____________________________________Exp. Date: ____________

Cardholder's Signature: ____

If paying by check make checks Payable to **"SMCAANA"**.

Please send information and Payment to

SMCAANA 250 East Liberty street Ste 801
Louisville, KY 40202

*** **Physician in Training Dues exempt only with Confirmation Letter from Program Director or Copy of Contract**