

HCMA MEMBERSHIP APPLICATION (Page 2)

Name of person who recruited you: _____

By my signature, I agree to accept and be bound by the Articles of Incorporation and Bylaws of the HCMA, and the Principles of Medical Ethics of the AMA, together with all future amendments of such Articles of Incorporation, Bylaws, or Principles of Medical Ethics, which may be duly adopted by the respective organizations.

I, hereby release, and hold harmless from any liability or loss, the HCMA, their officers, agents, employees, and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership. I understand that any false or misleading statements made on my application may be ground for denial of membership or probation or censure by, or suspension of expulsion from, the HCMA.

I hereby certify that the foregoing is true and correct to the best of my knowledge. I understand and agree that if I knowingly make a false representation in this application, or a representation that in the exercise of reasonable care I should have known to be false, the HCMA has the authority to reject this application.

Printed Name: _____ Date: _____

Signature: _____

(You can reach the HCMA Headquarters at 813/253-0471)

Medical Student/Intern/Resident Member Dues

HCMA (1 year) \$10.00
Pre-pay (up to 4 yrs) \$25.00

Strongly Recommended

(circle additional dues and add to your total)
Alliance (Spouses) \$ 97
Foundation \$100
HILLPAC \$ 50

Total Remitted:\$ _____ Check #: _____

Make check payable to "HCMA" and mail to: HCMA, 606 S. Boulevard, Tampa, FL 33606

CREDIT CARD PAYMENT: _____ Master Card _____ VISA _____ EXP DATE: _____

CARD # _____

Authorized Signature: _____

HCMA Members are now offered the option of automatic renewal. By signing below you will authorize the Hillsborough County Medical Association to automatically charge the above credit card to renew your dues in September of each year. To participate in this program, please sign below:

X _____ Printed name: _____