Alameda-Contra Costa Medical Association / California Medical Association
6230 Claremont Avenue, Oakland, CA 94618 T: (510) 654-5383 F: (510) 654-8959

MEMBERSHIP APPLICATION

PERSONAL INFORMATION

Name:
(as it appears on CA MD/DO license)

Date of Birth (required):	Place of Birth:	Sex:	☐ Female ☐ Male
Primary Address:			
City:	State:	Zip:	
Phone:	Fax:	Email:	
Primary Specialty:		Secondary Specialty:	
Practice Name:		Number of physicians:	

MEDICAL LICENSURE

Calif Medical License No:	Date Issued:
Other Medical License No:	Date Issued (if known):

Has Your medical license in California or elsewhere ever been revoked, suspended, or placed on probationary status? ☐ Yes ☐ No

If yes, please provide details on a separate sheet of paper and attach it to this application.

CURRICULUM VITAE

☐ I have enclosed a copy of my CV.

☐ In lieu of enclosing my CV, I have completed the additional information on the reverse.

I agree to conform to the bylaws of the Alameda-Contra Costa Medical Association.

I am aware that information submitted in this application and additional information obtained by the Alameda-Contra Costa Medical Association will be verified. I hereby authorize other organizations having information relating to this application, including but not limited to hospital medical staffs, other medical societies, medical schools and governmental and regulatory entities, to release any and all such information to the Alameda-Contra Costa Medical Association. I hereby authorize the Alameda-Contra Costa Medical Association to make known to hospitals and other medical organizations upon request any information the Association may have concerning me.

SIGNATURE ______________________ **DATE** ______________________

Return your completed application to the ACCMA by fax (510-654-8959)
or by mail (6230 Claremont Ave, Oakland, CA 94618)

Additional Contact Information

Address: ☐ Residence ☐ 2nd Office
City: State: Zip:
Phone: Fax:

Address: ☐ Residence ☐ 2nd Office
City: State: Zip:
Phone: Fax:

Education and Training

Medical School:	State:	Degree:	Grad Year:
Additional Education:	State:	Degree:	Grad Year:
Internship:	State:	Start Year:	End Year:
Residency:	State:	Start Year:	End Year:
Fellowship:	State:	Start Year:	End Year:
Additional Training:	State:	Start Year:	End Year:

Military Service

Branch of Service: Start Year: End Year:

Professional History

List the dates and location of medical practice since completion of your training. Account for activities during any gaps your professional medical practice history. Attach additional sheet if needed.

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Professional Affiliations

Hospital Affiliations:
Professional Specialty Societies:
Other Professional Societies:
Are you currently a member of the California Medical Assn? ☐ Yes ☐ No
Have you ever been or are you now a member of any other state medical society? ☐ Yes ☐ No
Which ones?

Marital Status

☐ Married ☐ Single ☐ Domestic Partner Spouse/Partner Name: