



Membership Application

**Date of Application** \_\_\_\_\_

Name  
(First/MI/Last) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Preferred Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Sex \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

FAX \_\_\_\_\_ Email \_\_\_\_\_

Texas License Number \_\_\_\_\_ Specialty \_\_\_\_\_

College \_\_\_\_\_ City/State \_\_\_\_\_ Degree/Major/Date \_\_\_\_\_

Medical School \_\_\_\_\_ City/State \_\_\_\_\_ Degree/Date \_\_\_\_\_

Internship/Program \_\_\_\_\_ City/State \_\_\_\_\_ Dates \_\_\_\_\_

Residency/Program \_\_\_\_\_ City/State \_\_\_\_\_ Dates \_\_\_\_\_

Fellowship/Program \_\_\_\_\_ City/State \_\_\_\_\_ Dates \_\_\_\_\_

Board Certification: Primary Specialty/Date \_\_\_\_\_ Subspecialty/Date \_\_\_\_\_

Mode of Practice (Academic/Group/Solo/Government) \_\_\_\_\_

Other Professional Organizations \_\_\_\_\_

Fraternal/Social/Advocacy Organizations \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Please select preferred contact method:      Fax      Mail

Signature \_\_\_\_\_

Please send application to the address above.

Dues schedule (*include no money now; we will send invoice upon acceptance*)

Practicing physician	\$250/year
First year of practice	\$50/year
Resident/Fellow/Student	\$25/year

Membership Committee Recommendation: