APPLICATION FOR MEMBERSHIP

in the

HARTFORD COUNTY MEDICAL ASSOCIATION

CONNECTICUT STATE MEDICAL SOCIETY

100 Beard Sawmill Road, Suite 109, Shelton, CT 06484
Phone: (203) 513-2045 Fax: (203) 513-8036
Email: info@hcma.org / www.hcma.org

Name: ____ ☐ Male ☐ Female
Last (Indicate MD OR DO) First Middle initial

Medical Practice/Corporate Name: ____

Office: ____
Address City/Town State Zip

Office Tel: (____) ______________ Cell Phone: (____)______________ Fax: (____)______________

Home Address: ______________________ City: ____________ State ______ Zip: ____________

Date of Birth: _____/_____/______ Preferred Email: ____________________@____________________
M D Y

Office Manager Name: ______________________ Email: ______________@______________

I understand that by providing my fax number(s) and email addresses, I hereby consent to receive faxes/emails sent by or on behalf of the HCMA. HCMA will not share your cell phone or email address without your explicit approval.

I GIVE THE ASSOCIATION PERMISSION TO VERIFY THE INFORMATION CONTAINED IN THIS APPLICATION. ALSO, IF ELECTED TO MEMBERSHIP, I AGREE TO ABIDE BY THE BYLAWS OF THE ASSOCIATION.

Applicant's Signature: ________________________________ MD/DO Date: _____/_____/_____
M D Y

IF AVAILABLE, ATTACH CURRICULUM VITAE OR RESUME AND PHOTOGRAPH