



**CMDDA**  
**MEMBERSHIP APPLICATION**

**NAME:** \_\_\_\_\_  
(Last Name) (First Name) (Middle Name)

**PROFESSION:**  MEDICAL  DENTAL  OTHER  
IF OTHER, SPECIFY: \_\_\_\_\_

**TITLE:** \_\_\_\_\_ **SPECIALITY:** \_\_\_\_\_

**AFFILIATED HOSPITAL/UNIVERSITY:** \_\_\_\_\_

**MAILING ADDRESS:**  OFFICE  HOME  
\_\_\_\_\_  
\_\_\_\_\_

**PHONE # (W):** \_\_\_\_\_ **(H):** \_\_\_\_\_ (optional)  
**FAX #:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**ACTIVE MEMBERSHIP FEE:**

ANNUAL: SINGLE \$50 COUPLE \$75 (US/Canadian \$ depending on where you reside)  
LIFE MEMBER: \$500 \$750

**STUDENT/ASSOCIATE MEMBERSHIP FEE:**

ANNUAL: SINGLE \$25 COUPLE \$40  
LIFE MEMBER: \$250 \$400

**SPOUSE:** \_\_\_\_\_  
Is he/she a health care professional:  YES  NO  
IF yes please complete another application for him/her

**CHILDREN: (Name/Age)-Optional**

\_\_\_\_\_  
\_\_\_\_\_

Do you have any objection in CMDDA sharing your demographic information with reliable community resources working with the Tamil community?  YES  NO

In which of the CMDDA activities you wish to contribute/you are interested:

\_\_\_\_\_

**DECLARATION:**

I have reviewed the Constitution of CMDDA. Hereby I wish to become an active member of CMDDA and have enclosed payment of my membership fee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date