PMCAA Membership Application

Last Name:____

First Name:____________________Middle Initial:_______Gender:_____

Address:___________________________________ Home ☐ Office ☐

City:____________________________________State:_______Zip:______

Office Phone:__________________ Home Phone:___________________

Fax:______________ E-mail:__________________________________

College:____

Year of Graduation:_______ Speciality:___________________________

www.pmcaa.net

Patiala medical College Alumni Association

Is your spouse a Doctor? Y ☐ N ☐ If yes, complete the following:

Spouse's Name:____
Last First Middle Initial

Address:____

City:______________________________ State:_____________________ Zip:____________________

E-mail:____

Office Phone:______________________________ Fax:_______________________________________

College:__________________________ Year of Graduation:__________ Speciality:________________

MEMBERSHIP CATEGORIES:

☐ $1000 Life Membership

☐ $100 Annual Membership

☐ $2000 Joint Life Membership

☐ $200 Joint Annual Membership

PAYMENT INFO ☐ Check

Signature:___________________________________

Mail or Fax this application to: 2600 E. Southern Ave, Suite I-1, Tempe, Arizona 85282 Fax: 480-821-3806