CHINESE AMERICAN MEDICAL ASSOCIATION OF SOUTHERN CALIFORNIA (CAMASC)

625 West College Street, Ste 209, Los Angeles, CA 90012
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CAMASC Membership Application

Required Information Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____

City: _____ State:_____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

CA MD/DO License #: _____ Expiration Date: _____

Practice Specialty: _____

Type of Membership*		**I am a:**
☐ Physician in clinical practice	$200 Annually	☐ New Member ☐ Renewing Member
☐ Physician-in-Training or Medical Student**	$80 Annually	
Total Amount Enclosed: $_____		

* CAMASC reserves the right to adjust the membership benefits and fee as deemed necessary. Please call or email to confirm the current membership fee. Membership fee is based on a twelve (12) months cycle.
** Must enclose a letter of verification from an accredited institution.

Payment Method (choose one):
☐ Check Payable to "CAMASC"
☐ Credit Card – Direct Swipe (in-person or onsite only)
☐ Credit Card – Manual Entry (please provide information below)

Card Number: _____ Card Expiration Date: _____

Card Security Code: _____ Billing ZIP Code: _____

I authorize CAMASC to charge my credit card for the total amount indicated on this form.

Signature: _____ Date: _____

Please email or mail your application form to the office address above.
CAMASC is a 501(c) 6 non-profit corporation, all contributions or gifts to CAMASC are not deductible as charitable contributions for federal income tax purposes.

Office use only: Date Received: _____ Processed by: _____

Payment Method: Check #: _____ Credit card Invoice #: _____