



HMA Resident Membership Application Form

Annual dues for medical residents are \$10.00.

Terms: \$10.00 /Year. * = required information.

First Name* _____ M.I. _____

Last Name* _____ Degree/Suffix* _____

Address* _____

City* _____ State* _____ Zip* _____

Office Phone* _____ Mobile Phone _____

Email* _____

Assistant's Email _____

Specialty* _____

Website _____

Practice Status: Active Inactive

Medical School _____ Graduation Year _____

*Make checks payable to **Hawaii Medical Association**. Send completed form and payment to:*

*Hawaii Medical Association
attn: Membership
1360 South Beretania Street, Suite 200
Honolulu, HI 96814*