HMA Retired Physician Membership Application Form

Annual dues for retired physicians are $25.00.

Terms: $25.00 / 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