

WASHINGTON STATE DERMATOLOGY ASSOCIATION

APPLICATION FOR MEMBERSHIP

CONTACT INFORMATION:

Name: _____ Title: _____

Practice/Group Name: _____

Practice Address: _____ City/State/Zip: _____

Phone: _____ E-Mail: _____

Hospital Affiliation: _____

Home Address: _____

Home Phone: _____ E-Mail: _____

Preferred Address for WSDA Correspondence: Home Work

EDUCATION: (School Name/Location & Years Attended)

Premedical Education: _____

Medical School: _____

Residency: _____

Fellowship: _____

Board Certification: _____ Board Eligible: Yes No

Professional Society Memberships:

MEMBERSHIP CATEGORIES:

Active (\$100.00 Dues) Associate (\$75.00 Dues) Affiliate (\$75.00 Dues)

Membership Dues: (U.S. Funds) One-Year Membership (July 1 – June 30)

- Enclosed is my check for membership dues
- Please charge my Visa or MasterCard

Name on card: _____

Number: _____ Exp. Date: _____

Please return completed application along with payment to:

WSDA
2033 Sixth Avenue, Suite 1100
Seattle, WA 98121

Fax: (206) 441-5863
Email: smc@wsma.org
Questions? (206) 441-9762