



Join MAG's Resident Physician Section

Please complete the information below to apply for membership to the Medical Association of Georgia.

First Name _____ Middle Initial ____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Sex _____ Date of Birth _____

Residency Location _____

Specialty _____

Expected Residency Program Completion Date _____

Payment Information - \$75 Resident Dues (For the Duration of Your Residency & Fellowship)

Payment Method: ___ Check (Made payable to the Medical Association of Georgia)
 ___ Credit Card (check one) ___ Visa ___ MC ___ AMEX

Name (as it appears on card): _____

Number: _____

Expiration Date: ____/____

Signature: _____

MAG Encourages you to get involved in organized medicine locally, by joining your county medical society.

Check here if you would like to join your county medical society.

For more information, call 800.282.0224, ext. 9268 go to www.mag.org

Please mail or fax membership application to:

Medical Association of Georgia

PO Box 101993

Atlanta, GA 30392-1993

(Fax) 678.303.9264

www.mag.org