MAG Resident Physician Section Membership Application

First name _____ M.I. _____ Last name _____

Gender _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Residency location _____ Residency completion date _____

Payment information: $75 covers membership for duration of residency

Payment Method _____ Cash

_____ Check (made payable to "Medical Association of Georgia")

_____ Credit card ____Visa ____MC ____ AMEX

Name (as it appears on card) _____

Card number _____

Expiration date _____ /_____

Signature _____

Please mail or fax membership application to:
Medical Association of Georgia
P.O. Box 105774
Atlanta, GA 30348
Fax: 678.303.9264
Contact Lesley Nevins at Lnevins@mag.org for additional information