



For mailing please use:  Office address  Home address

(Please print.)

\_\_\_\_\_  
Last Name First Middle MD/DO

\_\_\_\_\_  
Office Address City State Zip

( ) ( ) ( )

\_\_\_\_\_  
Office Telephone Office Fax Home Telephone

\_\_\_\_\_  
Home Address City State Zip

\_\_\_\_\_  
Personal E-Mail Address

\_\_\_\_\_  
Social Security No. SC Medical License No. Date of Birth

\_\_\_\_\_  
Medical School/Year Graduated

\_\_\_\_\_  
Residency Programs/ Year Completed

\_\_\_\_\_  
Number of Years in Practice Specialty Spouse's Name

\_\_\_\_\_  
Name of County Medical Society which you are a member

(Subject to verification)

**PRACTICE INFORMATION**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Self, Solo                                | <input type="checkbox"/> Group, Multi-Specialty<br>(please specify) | <input type="checkbox"/> State Government         | <input type="checkbox"/> Hospital Based    |
| <input type="checkbox"/> Group, Same Specialty<br>(please specify) | <input type="checkbox"/> 1-3 Physicians                             | <input type="checkbox"/> Military                 | <input type="checkbox"/> Hospital Employed |
| <input type="checkbox"/> 1-3 Physicians                            | <input type="checkbox"/> 4-7 Physicians                             | <input type="checkbox"/> Retired (please specify) | <input type="checkbox"/> Academic          |
| <input type="checkbox"/> 4-7 Physicians                            | <input type="checkbox"/> 8+ Physicians                              | <input type="checkbox"/> Not Practicing           |  |
| <input type="checkbox"/> 8+ Physicians                             | <input type="checkbox"/> Other Private Employer                     | <input type="checkbox"/> less than 10 hours/week  |  |
|  |   | <input type="checkbox"/> less than 30 hours/week  |  |

**PLEASE CHECK MEMBERSHIP DUES INCLUDED IN YOUR PAYMENT**

	SCMA Rate	AMA Rate (add amount to SCMA Rate)
Regular Member	<input type="checkbox"/> \$395	<input type="checkbox"/> \$420
1st Year Medical Practice After Residency	<input type="checkbox"/> \$298	<input type="checkbox"/> \$210
2nd Year Medical Practice After Residency	<input type="checkbox"/> \$298 *	<input type="checkbox"/> \$315
* 2nd Year physician's rate is free when joining during 1st year in practice after completing residency.		
Military	<input type="checkbox"/> \$70	<input type="checkbox"/> \$280
Fellow/Resident/Intern	<input type="checkbox"/> \$20	<input type="checkbox"/> \$45
Medical Student	<input type="checkbox"/> \$10	<input type="checkbox"/> \$20
MEDPAC/AMPAC	<input type="checkbox"/> \$150	
AMA Foundation	<input type="checkbox"/> \$10	
SCMA Foundation	<input type="checkbox"/> \$25	

Payment Method:  Check made payable to SCMA  Visa  MasterCard  Visa Debit  MasterCard Debit

Credit Card No. \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature Required if Paying by Credit Card \_\_\_\_\_

Cardholder's Name (Please Print) \_\_\_\_\_

Credit Card Billing Address \_\_\_\_\_