Pennsylvania Rheumatology Society

Application for NEW Membership

Date ______________________________

Name: ____
(Last) (First) (MI)

Office Address: ____________________________ Home Address: ____________________________

____________________________ ____________________________

Office Telephone: ____________________________ Home Telephone: ____________________________

Fax: ____________________________ Preferred Address: ☐ Home ☐ Business

Email address: ____

Education:

Medical School: ____________________________ Date: ______ to ________ Degree: ______

Residency: Institution: ____________________________ Date: ______ to ________

Institution: ____________________________ Date: ______ to ________

Hospital Affiliation (name/address): ____

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MAIL COMPLETED APPLICATION TO:

Pennsylvania Rheumatology Society
777 East Park Drive, P.O. Box 8820
Harrisburg, PA 17105-8820
Phone (717) 558-7750
Fax (717) 558-7841

Enclose $40 membership fee payable to PRS or complete the MC/VISA information below

MC/VISA#: ____________________________ **Exp Date:** ____________________

Name on Card: ____

Signature: ____

Show Your Support and Be Part of a Growing List of Professionals