



Philippine Medical Society of Northern California

Application for Membership

Active _____ Associate _____

Name: _____ Birthdate: _____

Type of Medical Practice: Sales _____ Group _____
Private _____ Government _____ Military _____

Office Address: _____
Street City State Zip Code

Home Address: _____
Street City State Zip Code

Office Phone: _____ Home Phone: _____

I prefer to receive my mail: at Home _____ at the Office _____ by eMail _____

Civil Status: Single _____ Married _____ Name of Spouse _____

California License Number: _____ Expiration Date: _____

County Medical Society Member _____

Board Certification _____ Year _____

Medical School _____ Year of Graduation _____

Philippine License: Year _____ Expiration Date: _____

Internship: _____ Year _____

Residency: _____ Year _____

Residency: _____ Year _____

Fellowship: _____ Year _____

Sponsors: _____

(Active PMSNC member in good standing)

Have you ever had your Medical License suspended or revoked? Yes _____ No _____

I hereby declare that all the above statements are true and correct.

Date: _____

Signature

Please enclose 1. a recent passport size photo, and

2. Membership fee \$100 (Active) \$50 (Associate)

Send completed application form to the office of the PMSNC Secretary:

Lucita Cabrerros, M.D.

479 St. Francis Blvd.

Daly City, CA 94015