



## Resident Physician Section Membership Application

To request membership as a resident in the West Virginia State Medical Association's Resident Section (WVSMA-RPS), please complete this form and mail it along with a check for dues in the amount of \$30 to WVSMA P.O. Box 4106 Charleston, WV 25364. If you have any questions, call (304) 925-0342 ext. 16.

Name \_\_\_\_\_  
*(full name please, no initials)*

Preferred Mailing Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

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

Medical School \_\_\_\_\_

Year Graduated \_\_\_\_\_

Residency Year \_\_\_\_\_ (1<sup>st</sup>, 2<sup>nd</sup>, etc)

Name and Address of Residency Program \_\_\_\_\_

\_\_\_\_\_

Specialty/Type of Residency \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date