

# ***NEW JERSEY RHEUMATOLOGY ASSOCIATION***

## **APPLICATION FOR MEMBERSHIP**

Name: \_\_\_\_\_

Office address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Preferred Mailing Address (check one): Home: \_\_\_\_\_ Office \_\_\_\_\_

Medical School: (Name, Location, Dates, Degree) \_\_\_\_\_

\_\_\_\_\_

State Licenses: (State, Year, License Number) \_\_\_\_\_

\_\_\_\_\_

Specialty Certification IF APPLICABLE: (Board, Date)\_\_\_\_\_

List other professional societies of which you are a member:\_\_\_\_\_

\_\_\_\_\_

Hospital Affiliations:\_\_\_\_\_

\_\_\_\_\_

Teaching or Academic Appointments:\_\_\_\_\_

\_\_\_\_\_

Type of Practice:  Private Practice  Industry  Academic  Hospital Based

Applicants Signature\_\_\_\_\_ Date:\_\_\_\_\_

**Membership Annual Dues: \$75.00**

Please make checks payable and mail to:

**The New Jersey Rheumatology Association  
100 South Jefferson Road  
Suite 204  
Whippany, NJ 07981**