



**IMA-USA Chapter**  
**PO Box 13978**  
**Tallahassee, FL 32317**  
**850/656-1078**  
**Fax: 850-656-3038**  
**www.ima-wf-usa.org**

**US Chapter**

**Israeli Medical Association World Fellowship  
 United States of America Chapter  
 Charter Member Renewal Application**

Qualified Medical Professional:

(Please Print)  **Please do not publish/give my information to other members**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Profession/Credentials: \_\_\_\_\_ Field of Medicine: \_\_\_\_\_

Work Organization: \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Work Fax: \_\_\_\_\_ Cell #: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Home Fax: \_\_\_\_\_

Home Email: \_\_\_\_\_ Home Cell# \_\_\_\_\_

<p>Medical Student          Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Field of Study: _____          Year of Graduation: _____</p>
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**2009 Charter Member Renew Dues \$150.00**

**Resident / Medical Student Dues \$50.00**

**Additional Contribution \$\_\_\_\_\_ (optional)**

**Total: \$ \_\_\_\_\_**

Pay by :  Check (payable to IMAWF-USA) or  Credit Card

MasterCard  Visa  American Express

Name on card: \_\_\_\_\_

Card #: \_\_\_\_\_ Exp Date: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature

Date