MEDICAL ASSOCIATION OF JAMAICA
19a Windsor Avenue, Kingston 5, Jamaica W.I.
Tel: (876) 946-1105-7, Fax: (876) 946-1102
Email: medassnjam@cwjamaica.com
Web Page: www.medicalassnjamaica.com

APPLICATION FOR MEMBERSHIP

I hereby apply for membership in the Medical Association of Jamaica:

……..
SURNAME GIVEN NAMES

HOME ADDRESS:……..……

……..

OFFICE ADDRESS:……

……

SEX: MALE FEMALE

TELEPHONE: (w)…… (h)…….…….. (c) ……..

FAX: (w)..…… (h) ……

EMAIL ADDRESS (Personal) …… (Work)……
Indicate your preference (mailing) { } Personal { } Work
{ } Home { } Office

DATE OF BIRTH: MONTH:…… DATE:…….. YEAR:……..

MEDICAL QUALIFICATIONS:

A) DEGREE, DIPLOMA, ETC……

B) YEARS TRAINED:……..

C) INSTITUTION(S):……

……..

DATE OF REGISTRATION AT MCJ:……..……

TYPE OF PRACTICE: ☐ General Practice

☐ Specialist

{ } Obstetrics & Gynaecology
{ } Internal Medicine
{ } General Surgery
{ } Paediatrics
{ } Dermatology
{ } Gastroenterology
{ } Plastic Surgery
{ } Orthopaedic Surgery
{ } ENT Surgery
{ } Cardiology
{ } Nephrology
{ } Respiratory

Other _____

{ } Private Practice { } Employed by Government

{ } Hospital

{ } Primary Care

MARITAL STATUS:……

HOBBIES & INTERESTS:……

FOREIGN LANGUAGE(S):……

MEDICAL PUBLICATION(S):……

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I agree to abide by the Regulations, By-Laws and the Rules of the Medical Association of Jamaica to which I may belong or with which I may at any time be associated (as the case may be) and to pay my annual subscriptions.

FEE SCHEDULE:	Medical Students	- Free
	Interns	- JA $2,000 per annum (Jan – Dec)
	Full Membership	- JA $5,000 per annum (Jan – Dec)

I enclose my cheque for $…….. to cover subscription for 1/ 2/ 3/ years (delete as necessary).

……

SIGNATURE DATE

FOR OFFICE USE ONLY

Payment Type	**Amount Received**	**NUMBER ASSIGNED**

_____ _____

ADMINISTRATOR'S SIGNATURE DATE

_____ _____

AUTHORIZED SIGNATURE DATE