



A.B.W.P.
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www.blackwomenphysicians.org

ASSOCIATION OF BLACK WOMEN PHYSICIANS 2009 MEMBERSHIP APPLICATION

Part 1: General Information

Name:	Degree(s):	Date of Birth:
Mailing Address:		
City:	State:	Zip Code:
Email Address:		
Business Address:		
City:	State:	Zip Code:
Home Phone:	Home Fax:	Cell Phone:
Business Phone:	Business Fax:	Pager:

Part 2: Professional Information

Medical School:	Degree:	Year:	Practice:
Post Graduate Training:		Years:	Years:
Specialty:	Board Certified:		
Specialty:	Board Certified:		

Please **do not** include me in the Printed Membership Directory.
 Please **do not** include me in the Website Membership Directory.

Part 3: Fees

Enclosed please find my check in the amount of (check one):

- | | |
|---|-----------|
| <input type="checkbox"/> Physician Member | \$150.00 |
| <input type="checkbox"/> Lifetime Member* | \$1500.00 |
| <input type="checkbox"/> Fellow/Resident | \$50.00 |
| <input type="checkbox"/> Medical Student | \$10.00 |
| <input type="checkbox"/> Donation | \$ _____ |

*Applicants are eligible for Lifetime Membership after a consecutive five-year membership.

- Black Enterprise Magazine Subscriptions are available to members at a cost of \$6.00 a year.
 Please make all checks payable to ABWP. \$ _____

TOTAL: \$ _____

Please charge my membership dues/donation to: Mastercard Visa

Account Number	Exp Date	Zip Code	Signature
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Part 4: Committees

I am interested in serving on the following committees:

- | | | |
|--|---|---|
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Golf & Tennis Tournament | <input type="checkbox"/> Speaker's Bureau |
| <input type="checkbox"/> Bylaws | <input type="checkbox"/> Membership | <input type="checkbox"/> Strategic Planning |
| <input type="checkbox"/> Charity Benefit | <input type="checkbox"/> Public Relations | <input type="checkbox"/> Technology (Website) |
| <input type="checkbox"/> Education | <input type="checkbox"/> Retreat | <input type="checkbox"/> Wellness Series |
| <input type="checkbox"/> Finance | <input type="checkbox"/> Scholarship Selection | |
| <input type="checkbox"/> Fundraising | <input type="checkbox"/> Sister 2 Sister | |

Please make all checks payable to the Association of Black Women Physicians (ABWP).

Signature:	Date:
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