

# Application

## Hungarian Medical Association of America

Name:

Date:

Citizenship:

Home address:

Office address:

City:

City:

State:

State:

Zip:

Zip:

Country:

Country:

Phone:

Phone:

Fax:

Fax:

E-mail:

E-mail:

Preferred mailing address:

Home

Office

Medical school:

Year of graduation:

Board certified:    yes            no

Specialty:

Subspecialty;

Attending Fellow Resident    Retired    Medical student ( circle appropriate)

Professional interests:

Please list your employment

Name of references:

How did you find HMAA?

HMAA Member you know:

Credit Card Number

Expiration date:

Please attach list of publications:

**Dues:**      **Active:**            \$150.00                 **Retired:**            \$ 60.00                 **Resident:**            \$ 25.00**Mail to:****Stephen Mechtler MD****4892 Eastbrooke Place****Williamsville, NY 14221**

E-mail: FRADIKA13@msn.com

Thank you for your cooperation.

**Enjoy your membership!!!!**