

RIMWA MEMBERSHIP APPLICATION

Name _____

Mailing Address _____

City, State, Zip _____

Telephone _____

Specialty(s) _____

Email address _____

Are you a member of the American Medical Women's Association? ___ yes ___ no

Membership Categories

- Active \$95
- Academic Associate \$95
- Associate \$35 (check one)
 - ___ Resident (dues are \$10 for residents in the first year of training)
 - ___ Fellow
 - ___ Physician in first year of practice
 - ___ Retired Physician
 - ___ Student – no dues

Please mail completed form and payment to:

Rhode Island Medical Women's Association
235 Promenade Street, Suite 500
Providence RI 02908

Please make checks payable to "Rhode Island Medical Women's Association"
For additional information call 331-3207.