Women's Medical Association of Fairfield County
2025 Membership Application

Dear Colleague,

We had some wonderful lectures in 2024! We are looking forward to another year of great conferences and memorable gatherings. Members will continue to receive advanced notice of all activities. If you wish to renew your membership, please fill out this form. Remember to tell your colleagues about our organization! Also, if you work in a hospital, we would love for you to encourage the residents to join or have you invite them as your guests. Thank you for your continued support!

To renew your membership, kindly return this completed application to:

Rose Tamora, MD
41 Sullivan Drive
Redding, CT 06896

Please write legibly and fill out all information.

Physician's Name_____**, MD / DO**

Office Address_____
Street

_____
City, State, ZIP Code

_____
Phone Number

Home Address_____
Street

_____
City, State, ZIP Code

_____
Phone Number

Would you prefer to receive mailings at [ ] Home or [ ] Office?

Your home address will NOT be published in the directory.

E-Mail Address: _____

Medical Specialty: _____
Board Eligible / Certified

Annual Dues: Credit Card Information: [ ] Attending Physician ($80)
[ ] Retired Physician ($35) [ ] [ ]
[ ] Resident/Fellow Physician ($10)
[ ] [ ]

Payment Method:
[ ] Check (enclosed, made payable to *WMAFC, Inc*) Card Number: _____ [ ]
PayPal® (online at www.WMAFC.org)
[ ] Credit Card (note $3 processing fee will be added) Expiry: _____ /_____ (MM/YY) CVV: _____
Membership: Billing Address: _____ [ ] Renewing membership
[ ] New membership Billing Address: _____