Yakima County Medical Society
PO Box 706
Yakima WA 98907
509-969-5488
kayfunkmd@ycms.org

2018 MEMBERSHIP RENEWAL

Name_____
(first) (middle) (last)

Practice/Clinic Name _____

Preferred Email _____

I WILL CONFORM TO THE Yakima County Medical Society Constitution and Bylaws as they now stand or as they may be amended by this organization from time to time. I shall forward my annual dues to the Society office upon receipt of a statement.

Signature _____ Date _____

As a Unified county society, Yakima County Medical Society bylaws require physician members to hold joint membership with either the Washington State Medical Association (WSMA) or the Washington Osteopathic Medical Association (WOMA).

Are you a member of the Washington Osteopathic Medical Association (WOMA)? ☐ Yes ☐ No

If yes, please designate only your Yakima County Medical Society membership category below
*If no, please indicate **both** your Yakima County Medical Society and WSMA membership categories and calculate your total payment accordingly*

	Yakima County Medical Society Dues		Washington State Medical Association Dues
☐	$150 Full Active Member	☐	$535* Full-time Active Physician
☐	$75 Physician Assistant	☐	$293* 2nd Year in Medical Practice
☐	$0 Retired Physician	☐	$0 1st Year in Medical Practice
☐	$0 Resident Physician	☐	$317* Limited Practice (fewer than 20 hours per week)
		☐	$125* Physician Assistant
		☐	$0 Fully Retired (Retirement Date _____)
		☐	$0 Resident (Expected Date of Completion_____)

Most WSMA members who are insured by Physicians Insurance receive a discount of $300 on their liability insurance premium. Call Physicians Insurance at (206) 343-7300 for details.

* WSMA dues include a $25 contribution for the Washington State Medical Political Action Committee (WAMPAC) or WSMA Foundation for Health Care Improvement, a not-for-profit 501(c)(3) organization which supports improvements in the quality and delivery of health care services for all Washingtonians. Please select WAMPAC or WSMA Foundation to indicate where you'd like your contribution directed. ☐ WAMPAC ☐ WSMA Foundation for Health Care improvement

Total Payment Amount $ _____

Payment Method:

☐ Check enclosed (please make payable to **WSMA**)

☐ Credit Card (VISA or Mastercard only)

Card number _____ Expiration Date_____/_____

Signature_____

Please mail this application and payment to:

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