

MALAYSIAN MEDICAL ASSOCIATION
4TH FLOOR MMA HOUSE, 124 JALAN PAHANG
53000 KUALA LUMPUR

Tel no. 603-40411375, Fax no. 603-40419929

MMA Homepage : www.mma.org.my E-mail : membership@mma.org.my / aids@mma.org.my

MMA MEMBERSHIP SUBSCRIPTION RENEWAL FORM

To : The Honorary General Treasurer

Yes, I am interested in renewing my membership. Enclosed is a crossed cheque: Bank/MO/PO No (to include 0.50 sen for outstation cheque) payable to “**Malaysian Medical Association**”. I opt to pay by credit card as per the form enclosed. The type of membership and appropriate amount paid is ticked as below:

- House Doctor RM150 Associate Member RM250 Overseas Ordinary Member RM500 Student Member RM20
- Ordinary Member RM250 If Joint Ordinary Member (with spouse) RM125 **Total RM375**

1st to 10 year Medical Officer (MO) **RM150** (*please tick in the appropriate boxes on the number of years you have served to qualify for the lower subscription fee*) 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th

My latest particulars are as follows :-

- 1) Name of member : (In Caps) : _____
- 2) NRIC no. (New) : _____ (Old) : _____ 3) Colour of I/C _____
- 4) Date of Birth : _____ 5) Sex : Male Female 6) Religion : _____ Race : _____
- 7) Specialty : _____ 8) MMC reg. no : _____ 9) Date of registration with MMC : _____
- 10) Last paid MMA Subscription on : _____ 11) Subscription Expired on : _____
- 12) Marital Status: M S Spouse name if married _____ Spouse new I/C no. _____
- 13) Employment status : Please tick in the relevant boxes.
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> (A) Armed Forces - | <input type="checkbox"/> Medical Officer | <input type="checkbox"/> House Officer | <input type="checkbox"/> Registrar |
| <input type="checkbox"/> (AS) Armed Forces - | Specialist | | |
| <input type="checkbox"/> (G) Government - | <input type="checkbox"/> Medical Officer | <input type="checkbox"/> House Officer | <input type="checkbox"/> Registrar |
| <input type="checkbox"/> (GS) Government - | <input type="checkbox"/> Specialist | <input type="checkbox"/> Public Health Specialist | |
| <input type="checkbox"/> (P) Private - | <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Private Medical Officer | |
| <input type="checkbox"/> (PS) Private - | Specialist | | |
| <input type="checkbox"/> (U) University - | <input type="checkbox"/> Medical Officer | <input type="checkbox"/> House Officer | <input type="checkbox"/> Registrar <input type="checkbox"/> Lecturer |
| <input type="checkbox"/> (US) University - | Specialist | | |

14) Professional Qualifications : (Basic Degree and One Postgraduate qualification only)
(Please state the full date you obtained the degree as our computer system does not accept 'part' date)

QUALIFICATION	DEGREE	UNIVERSITY	COUNTRY	DATE OF QUALIFICATION		
				D ate	M onth	Year
1. Basic Degree						
2. Postgraduate						

Please tick in the box for your correspondence address : Working House

WORKING ADDRESS

HOUSE ADDRESS

 Post-code _____ Mobile No _____
 Tel. no. _____ Fax no. _____
 E-mail _____

 Post-code _____
 Tel. no. _____ Fax no. _____
 E-mail _____

Signature : _____ Date: _____ membership renewal **form.....05122007**

