

## MMA MEMBERSHIP REJOINING FORM

To : The Honorary General Treasurer

Yes, I am interested in rejoining the MMA. 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:

- |   |                             |                    |                      |
|---|-----------------------------|--------------------|----------------------|
| <input type="checkbox"/> House Doctor             | RM150 + RM100 rejoining fee | <b>Total RM250</b> |                      |
| <input type="checkbox"/> Associate Member         | RM250 + RM100 rejoining fee | <b>Total RM250</b> |                      |
| <input type="checkbox"/> Overseas Ordinary Member | RM500 + RM100 rejoining fee | <b>Total RM600</b> |                      |
| <input type="checkbox"/> Ordinary Member          | RM250 + RM100 rejoining fee | <b>Total RM350</b> | } <b>TOTAL RM575</b> |
| If Joint Ordinary Member (with spouse)            | RM125 + RM100 rejoining fee | <b>Total RM225</b> |                      |

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

**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 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 on 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: \_\_\_\_\_ rejoining **form....05122007**

MALAYSIAN MEDICAL ASSOCIATION  
4<sup>TH</sup> FLOOR MMA HOUSE 124 JALAN PAHANG  
53000 KUALA LUMPUR

TEL : 603-40411375 FAX : 603-40419929/603-40418187 MMA Homepage : www.mma.org.my  
E-mail: membership@mma.org.my / aids@mma.org.my

**CREDIT CARD PAYMENT INSTRUCTION FORM (PIF)**

I hereby authorise (name of bank) ..... to debit my account

Please tick the relevant box  Master Card OR  Visa Card for the payment of subscription fee/s  
as indicated in the attached form  MMA Membership Renewal OR  Rejoining MMA Membership

Life membership  New MMA membership  
RM

Life Memberhip .....

Rejoining MMA Membership fee (if applicable).....

MMA Membership Subscription fee for year ( ..... ) .....

**TOTAL**

\_\_\_\_\_  
=====

**DETAILS OF CARDHOLDER**

Cardholder's name (as stated in the credit card : \_\_\_\_\_

Full Name : \_\_\_\_\_

I/C no : new : \_\_\_\_\_ old: \_\_\_\_\_

Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Postcode : \_\_\_\_\_ E-mail: \_\_\_\_\_

Office Tel no : \_\_\_\_\_ HP : \_\_\_\_\_

Card Expiry date: \_\_\_\_\_ Code No:

Name of Bank : \_\_\_\_\_ Master/ Visa credit card account no :

I agree to the terms and conditions of the platinum/gold/classic cardholder agreement which have been made available to me.

Cardholder's signature :

(as per the signature on the credit card) : \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE**

Merchant Number : \_\_\_\_\_

Authorisation code : \_\_\_\_\_

Authorisation date : \_\_\_\_\_

Verified by (name of staff) : \_\_\_\_\_

Signature : \_\_\_\_\_

Date : \_\_\_\_\_