



APPLICATION FOR MMA GIFT MEMBERSHIP

(Please type or print)

Gift Recipient Information: (complete info if known)

1. Full Name _____ Degree _____ Phone _____

2. Current Address _____

City: _____ State: _____ E-mail: _____

3. *Marital Status (Spouse Name) _____

4. College Attended _____ *Graduation Year _____

5. *Medical/Dental/Health Profession School _____ *Graduation Year _____

6. *Internship/Residency, etc. _____ *Years _____

_____ *Years _____

7. Specialty _____ *Specialty Board Status _____

8. Church/Congregation _____ *Conference _____

9. *Special Service Record: Any previous MCC or Mission Board related service; Relief work, VS, 1-W, SET etc. _____ *When _____

10. I believe this person to be in harmony with the purposes and standards of the MMA as outlined in the Constitution and the Statement of Faith of Mennonite Medical Association.

Signed: (donor) _____ Date _____

*information not critical to application, can be determined later

Gift Donor Information:

Name _____ Degree _____ Phone _____

Current Address _____ E-mail _____

City _____ State _____ Zip _____

\$40 (\$25 – student) Gift membership dues paid _____ Check #: _____

July 17, 2008

Sam Showalter M.D., Executive Secretary
Jan Showalter, R.N., Administrative Assistant
183 Grandview Drive, Harrisonburg, VA 22802

Telephone/FAX: 540-433-5090
E-Mail: sajmma@aol.com
Web Site: www.mennmed.org