

PROFESSIONAL INFORMATION

Name _____
Last Name First Name and Middle Initial Degree
Clinic or Business Name _____
Street Address _____
City, State, Zip _____
Phone _____ FAX _____
E-mail Address _____
Effective Date at this Address _____

For Physician Assistant to be eligible for OMA membership, they must be supervised by a physician that is an OMA member in good standing.

Name of supervising physician _____ Specialty _____ OMA Member

 Yes No
 Yes No
 Yes No

Are you registered with the Oregon Board of Medical Examiners Yes No

Registration # _____ Date Granted _____

PERSONAL INFORMATION

Birth date _____ Birthplace _____ Male Female
Spouse's Full Name _____
Home Address _____
City, State, Zip _____ Home Phone _____
Send My Mail to Office Home

PA Signature

OMA Member/Supervising Physician Signature

OMA Dues for Physician Assistant Members are \$50.00

Make check payable to Oregon Medical Association.
OMA also accepts Visa and MasterCard.

Card # _____
Signature _____
Visa MC Exp. Date _____

Contact the OMA if you have any questions regarding your application at (503) 226-1555 or send an email to karen@theOMA.org. Please return this application with the appropriate dues to the address below or fax the completed application with credit card information to (503) 241-7148.

**Oregon Medical Association
5210 SW Corbett Avenue
Portland, OR 97239**