



CMIA

CALIFORNIA MEDICAL INSTRUMENTATION ASSOCIATION

Membership Application/Renewal by Mail

Mail completed application by with your membership dues payable to: **C.M.I.A. Statewide Corporate, Capitol, LA & San Diego applications also on line at www.CMIA.org**



CMIA

Date ___/___/___ **New Member** **Renewal**

CHAPTER *Mail STATEWIDE CORPORATE application & check to: P.O. Box 2265, Del Mar, CA 92014*
Please check the ONE Chapter that you wish to be a member of. Mail completed application, with check to that address

- | | | |
|---|--|---|
| <input type="checkbox"/> LOS ANGELES
P.O. Box 8113
Mission Hills, CA 91346 | <input type="checkbox"/> INLAND EMPIRE
9330 Jersey Blvd.
Rancho Cucamonga, CA 91730 | <input type="checkbox"/> BAY AREA
3000 Danville Bl., Ste. F, PMB 229
Alamo, CA 94507 |
| <input type="checkbox"/> CENTRAL COASTAL
P.O. Box 360
Camarillo, CA 93010 | <input type="checkbox"/> CAPITOL REGION
PO Box 13733
Sacramento, CA 95853 | |
| <input type="checkbox"/> NORTHERN CALIFORNIA
P.O. Box 577
Lakeport, CA 95453 | <input type="checkbox"/> SAN DIEGO
P.O. Box 2265
Del Mar, CA 92014-1565 | |

MEMBERSHIP TYPE

See Constitution posted on www.CMIA.org for descriptions. Membership applications are subject to approval

- Associate \$15.00 Individual \$25.00 Chapter Corporate* \$150.00 Statewide Corporate* \$300.00

* In addition to this membership, add an additional one time **charitable contribution of \$50.00 to the Frank Yip Memorial Scholarship Fund.**

APPLICANT/MEMBER

Name: _____

Job Title: _____

Employer/School: _____

CONTACT INFORMATION

Location: Work Home School *Use this address for Corporate invoicing*

Hospital/Company: _____

Department/Mail Stop: _____

Address: _____

City, State, Zip: _____

E-Mail Address: _____

Phone Number: _____ Fax Number: _____

ALTERNATE CONTACT INFORMATION

Location: Work Home School *Use this address for Corporate invoicing*

Hospital/Company: _____

Department/Mail Stop: _____

Address: _____

City, State, Zip: _____

E-Mail Address: _____

Phone Number: _____ Fax Number: _____

For Membership Committee Only

- Approved Rejected Date: ___/___/___ Membership kit sent: ___/___/___

California Medical Instrumentation Association
Board of Directors - 915 "L" Street, PMB C136 - Sacramento, CA. 95814
WWW.CMIA.ORG