



Please complete this application and return to the MMDA Office. P.O. Box 24475, Minneapolis, MN 55424
Fax to: 952-929-4363 (no cover required) Questions call: 952-929-9398

MINNESOTA MEDICAL DIRECTORS ASSOCIATION

MEMBERSHIP APPLICATION

NAME _____ Degree _____

PREFERRED MAILING ADDRESS _____ Home _____ Office _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

E-MAIL _____

MEDICAL SPECIALTY _____

**Annual dues are \$150.00 (M.D.) and \$40.00 for Associate Members (non-M.D.)
and expire on December 31 of each year**

Please list the name(s) and location(s) of the facilities where you serve as medical director: Attach a separate page if necessary.

FACILITY NAME _____

FACILITY ADDRESS _____

CITY _____ STATE _____ ZIP _____

ADMINISTRATOR'S NAME _____

PHONE NUMBER _____

FACILITY NAME _____

FACILITY ADDRESS _____

CITY _____ STATE _____ ZIP _____

ADMINISTRATOR'S NAME _____

PHONE NUMBER _____

Elected _____

_____ Date