



Vietnamese American Medical Professionals

Hội Y Nha Dược Florida

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2024 Annual Membership Application

Note: Membership is based on Calendar year from Jan through Dec

Last Name _____ Middle _____ First _____

Professional Designation (please circle)

MD DO DMD DDS PharmD OD PA-C ARNP DC Other: _____

Specialty _____

Mailing Address _____

Phone _____

Email: _____

Membership Dues	Tax Deductible Donations (Community Service, Magazines, CE courses, YND events)
<input type="checkbox"/> \$85 - One Year dues	<input type="checkbox"/> \$20
<input type="checkbox"/> \$210 - Three Year dues	<input type="checkbox"/> \$50
	<input type="checkbox"/> \$100
	<input type="checkbox"/> Other \$ _____
TOTAL	

I am paying by Check Credit Card Zelle to vampgroupfl@gmail.com

If paying by Zelle, please add vampgroupfl@gmail.com to your Contacts first.

Credit Card Payment Visa MasterCard

Name on Card: _____

Card Number: _____

Expiration Date: ____/____

Signature: _____

CVC (3 digit # on back of card): _____

Amount: \$ _____

Zip Code: _____

Date: _____

Please make check payable to **Vietnamese American Medical Professionals** and mail to the following address:

Son Ho, M.D.
2098 Osprey Avenue
Orlando, FL 32814

Thank you for your support!