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| **JOIN DOHCAF!!!** | | | | | | | | | | |
| **Dominican Health Care Association of Florida, Inc.**  **P.O. Box 145255, Coral Gables, FL 33114**  **+1-305-582-5794 · daisy@dohcaf.org** | | | | | | **MEMBERSHIP APPLICATION** | | | | |
| **NAME** | | Last Name (or Company Name) | | | | | | First | | Initial |
| **SPOUSE NAME** | |  | | | | | | **Referred by:** | | |
| **CREDENTIALS** | | \_\_\_\_MD \_\_\_\_DO \_\_\_\_DDS \_\_\_\_Not Applicable  \_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **SPECIALTY:** | | |
| **ADDRESS:** | | STREET ADDRESS | | | | | | **OFFICE #:** | | |
|  | | | | | | **FAX #:** | | |
| CITY | | | | | | **CEL #:** | | |
| STATE | | ZIP | | | | **E-MAIL:** | | |
| **GRADUATE or MEDICAL SCHOOL:** | |  | | | | | | **YEAR GRADUATED:** | | |
| **We would like for you to be an active member of our organization. Please let us know how you would like to be involved:** | | | | | | | | * Advisory Committee (various elective positions available) * Educational Presenter * Volunteer * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Membership Level**  (Please circle one) | **MEMBER** | | | | **AFFILIATE** | | | **MEDICAL STUDENT** | **GENERAL PUBLIC** | |
| MD, DO’s, and Dentists (***DCMA membership not applicable for Dentists***) | | | | RN, PA’s, FMG, and all other health care professionals. | | | Must present valid ID | Anyone with an interest in supporting the organization | |
| **$200**  **06/01/2020-12/31/2021** | | | | **$100 per year**  **06/01/2020-12/31/2021** | | | **$50**  **06/01/2020-12/31/2021** | **$300 per year**  **06/01/2020-12/31/2021** | |
| **Mail application along with dues to:** | **Dominican Health Care Association of Florida, Inc. (DOHCAF)**  P.O. Box 145255, Coral Gables, FL 33114  or scan and e-mail to daisy@dohcaf.org | | | | | | | | | |
| **Form of Payment** | **Check** | | **Credit Card** | | | | | | | |
| **Check # \_\_\_\_\_\_\_\_\_**  **Amount $ \_\_\_\_\_\_\_**  **Date \_\_\_\_\_\_\_\_\_\_\_** | | * Visa * Master Card * American Express * Discover | | | | Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expiration date \_\_\_\_\_\_\_\_\_\_\_\_\_ CVV# \_\_\_\_\_\_\_\_\_  Name on the card if different from registration name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **SIGNATURE** |  | | | | | | | | | |
| [**www.dohcaf.org**](http://www.dohcaf.org) **The Dominican Health Care Association of Florida is also on FB and Instagram!** [**@DOHCAF**](https://www.dohcaf.org) | | | | | | | | | | |

*All proceeds will benefit the Dominican Health Care Association of Florida, Inc. (DOHCAF), a 501(c)(3) Non Profit Corporation, Tax ID# 27-4582689, and its Mission to advance and promote the efforts of Health Care Professionals who embrace and support causes favorable to the Dominican community. A portion of your membership, ticket and/or sponsorship may be tax deductible. Consult your tax professional for final determination.* *DOHCAF is registered to solicit contributions with the State of Florida. A copy of the official registration and financial information may be obtained from the Division of Consumer Services by calling toll-free (800) 435-7352. Registration does not imply endorsement, approval or recommendation by the State.*