



California Society of Dermatology & Dermatologic Surgery

New Member Application

Contact & Professional Information: (please edit or complete where necessary)

First Name: _____ Last Name: _____ Suffix: M.D. or D.O.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

It is important for CalDerm to have an email address in order to send you electronic communications such as CalDerm Alerts and other time-critical information on legislative or regulatory matters. Your email address and contact information will not be shared outside CalDerm use. Please print email address legibly.

Membership Qualifications:

Membership in CalDerm shall be limited to individuals who meet the criteria set forth below for one of the three (3) classes of membership listed below (Complete CalDerm Bylaws can be found at www.calderm.org):

I. Active Physician Membership

Physicians who are Board Certified or Board Eligible in Dermatology by the American Board of Dermatology or who have been granted a subspecialty certification in dermatopathology by the American Board of Medical Specialties.

II. Resident or Fellow Membership

Physicians who are currently pursuing training in a recognized dermatology residency or fellowship that is accredited by the Accreditation Council for Graduate Medical Education and is located in the state of California.

III. Retired Physician Membership

Physicians who have retired from the practice of dermatology as a Board Certified or Board Eligible Dermatologist.

I certify that as of this membership year _____ that I am a:

Board Certified Dermatologist Board Eligible Dermatologist Dermatopathologist Resident or Fellow Retired Physician

Select Membership Dues Classification:

Approximately 50% of all dues collected by CalDerm are allocated to lobbying, advocacy and political expenditures. It is this portion of all dues collected that are considered non-deductible.

_____ Active Physician Membership – **\$300**

_____ Active Physician Membership, First Three (3) Years of Practice – **\$100**

_____ Resident or Fellow – **Complimentary** (A voluntary contribution is appreciated)

_____ Retired Physician – **Complimentary** (A voluntary contribution is appreciated)

_____ CalDerm PAC Contribution (voluntary) – **a donation of \$200 is suggested and appreciated**
(CalDerm PAC Contributions are not tax deductible)

Required Information for PAC Contribution: Are you Self-employed or an Employee

If Self-employed, please provide the legal name of your business: _____

If Employed, please provide the name of your employer: _____

Method of Payment:

_____ Check enclosed for \$ _____ Bill Credit Card (VISA & MasterCard Accepted Only)

Credit Card Number: _____/_____/_____/_____ Expiration: _____/_____

Please keep a copy of this application for your records and remit a copy with payment to:

CalDerm, 980 Ninth Street, PMB# 1600, Sacramento, CA 95814 or fax to (916) 244-0330

Contact by phone at (916) 498-1712 or via email at membership@calderm.org Visit our web site at www.calderm.org