

MAIL TO: Federation of Physicians and Dentists  
1310 Cross Creek Circle, Suite C2  
Tallahassee, Florida 32301  
FAX TO: 850-942-6722

## APPLICATION FOR PRIVATE PRACTICE MEMBERSHIP

PLEASE FILL OUT COMPLETELY  
PLEASE PRINT

Name \_\_\_\_\_ Degree \_\_\_\_\_ Specialty \_\_\_\_\_

Office Address \_\_\_\_\_ Office Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Fax \_\_\_\_\_ Group Name \_\_\_\_\_

Office Manager \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

**MEMBERSHIP: Dues are for one calendar year from the date of application.**

(After one year you will be re-invoiced if paying by check,; monthly & annual credit card charges will continue unless otherwise notified)

Annual Dues: \$712.00 \_\_\_\_\_ enclosed or by credit card \_\_\_\_\_ (fill in credit card information below) or  
Annual Dues with Political Action Contribution \$738.00 \_\_\_\_\_ enclosed or by credit card \_\_\_\_\_ (fill in credit  
card information below)

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Please circle your credit card type: **Visa / MC / Am Ex only**

If selecting a monthly deduction (for credit card deductions only), please indicate below:

\$59.33 (monthly) \_\_\_\_\_ or \$61.50 (monthly) with Political Action \_\_\_\_\_

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp. Date \_\_\_\_\_

(Am Ex 4-digit Security Code) \_\_\_\_\_

Billing Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_