



The College of Physicians of Philadelphia

SECTION ON PUBLIC HEALTH

Membership Application Form

Name: _____

Title _____ Organization _____

Mailing Address: _____

_____ Zip Code _____

Phone () _____ - _____ Membership fee: _____ \$35.00

Fax () _____ - _____ _____ \$20.00 as a Student

E-mail _____ _____ Fellow _____ New Member _____ Renewal

Areas of Interest: _____

Pay dues online. Log on to www.collegeofphysicians.org and follow the "PAY DUES ONLINE" link

Please charge my VISA Master Card

Card # _____

Expiration Date _____

Signature _____

If cardholder's name is different from member's, please indicate here:

or

Enclosed is my check for \$_____. Please make check payable to "**Section on Public Health, CPP.**"

Mail to: Section on Public Health
The College of Physicians of Philadelphia
19 South 22nd Street
Philadelphia, PA 19103-3097
Attn: Sofie Sereda

If you have any questions, please contact Sofie Sereda at 215-563-3737, ext. 232 or sereda@collphyphil.org