



Physician Office Managers Association of America

Renewal Membership Application

Member's Name _____ Credentials _____

First Last

Phone Number: _____

Email Address: _____

Practice Information

Practice Name _____

Membership Pledge

As a member of POMAA, I agree to demonstrate the dedication to gain knowledge in medical office management and to uphold the standards of the healthcare profession. I understand that my membership is non-transferrable and is valid for one year from the date my membership is renewed.

Signature _____ Date _____

Type of Membership

_____ Individual Membership \$129.00 _____ Student Membership \$89.00

Method of Payment

Check _____ Money Order _____ Credit Card _____
Credit Card Type: _____ Master Card _____ Visa _____ Discover _____ Amex

Card Holder's Name: _____
Last First MI

Credit Card Billing Address: _____
Street City State Zip Code

Credit Card Number: _____ Expiration Date: _____
MM/YY

CSC Number: _____

*3 digit # on the back of a Visa or MasterCard
4 digit # on the front of an America Express Card*

Card Holder's Signature _____

Please fax or mail this completed form to POMAA at the address or fax number listed below:

POMAA, P.O. Box 232, Dallastown, PA 17313
Phone: 1-877-782-5141 ~ Fax: 1-866-359-0561
memberships@pomaa.net ~ www.POMAA.net