Section I

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name: |       | Credentials: | [ ]  MD, [ ]  DO, |       |
| [ ]  Male | [ ]  Female | Date of Birth: |       | Married? [ ]  Yes | Spouse’s Name |       |
| Email: |       | Cell Phone: |       |
| Practice Name: |       | Fax Number: |       |
| Business Address (preferred mailing address? [ ]  Yes): |  | City, State, Zip: |  | Business Telephone: |
|       |  |       |  |       |
| Home Address (preferred mailing address? [ ]  Yes): |  | City, State, Zip: |  | Home Telephone: |
|       |  |       |  |       |

Section II

|  |  |  |  |
| --- | --- | --- | --- |
| Medical School: |       | Year of Completion: |       |
| Residency Program: |       | Year of Completion: |       |
| Fellowship Program: |       | Year of Completion: |       |
| North Carolina Medical License Number: |       |
| Is your practice limited to dermatology? | [ ]  Yes | [ ]  No | If no, additional practice area(s): |       |

Section III

|  |
| --- |
| \*Application **for Associate** membership requires recommendation by one Active NCDA member. |
| Sponsor’s Name: |       | Address: |       |

Section IV

|  |  |  |
| --- | --- | --- |
| Membership Type: | [ ]  $175 Active Member (MD, DO) | [ ]  $0 Resident or Fellow-in-Training Member |
|  | [ ]  $175 Associate Member (PA, NP)\* | [ ]  $0 Emeritus Member (retired from active clinical practice) |
| Payment Options: | [ ]  Check payable to NCDA | [ ]  MasterCard | [ ]  Visa | [ ]  AMEX |
| Card number: |       | Exp. Date: |       | CVV: |       |
| Applicant’s Signature |  | Date: |       |

**Complete and return this form by mail or fax to:**NCDA, PO Box 27167, Raleigh, NC 27611 | Fax: 919-833-2023