SOUTHWEST ASSOCIATION OF HISPANIC AMERICAN PHYSICIANS

SWAHAP

S.W.A.H.A.P 2010 Membership Dues

Name: _____
First Name **Middle Name** **Last Name**

MAILING ADDRESS: _____
Street Name **State** **Zip Code**

Specialty_____ **Check Number:**_____

MEMBERSHIP VALID FROM JANUARY 1, 2010 TO DECEMBER 31, 2010

	Amount Paid
Yearly Membership Dues…… $300.00	_____
Scholarship Fund (Optional)……..$50.00	_____
Total……..	_____

Dues include CME Tuition for 2010 SWAHAP Fall Congress

Dues must be paid by **No Later than April 1, 2010** in order to avoid late fees

Scholarship Fund is for Pre-Med Students in the community

Please send your check & this statement to the SWAHAP office at:

1444 Montana Suite 101
El Paso, Texas 79902

Updating SWAHAP member information:

HOME ADDRESS_____
Street Name

_____
City State Zip Code

HOME PHONE #: _____

EMAIL ADDRESS:_____

OFFICE ADDRESS _____
Street Name

_____
City State ZipCode

OFFICE PHONE #:_____

FAX #:_____

2010 SPOUSES PROGRAM MAILING INFORMATION

NAME:_____

HOME ADDRESS:_____