



## Membership Application

Name & Title \_\_\_\_\_

Credentials \_\_\_\_\_

Affiliation \_\_\_\_\_

Address \_\_\_\_\_

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

E-mail (**REQUIRED**) \_\_\_\_\_

Telephone (office) \_\_\_\_\_ Fax \_\_\_\_\_

**I would like to join or renew TMEDA and/or TGS membership:**

### **Membership**

\_\_\_\_\_ TMEDA Membership is \$75 per year.

### **Fees:**

\_\_\_\_\_ TMEDA/TGS joint membership is \$135 per year

\_\_\_\_\_ TMEDA Non-Physician Membership is \$37.50 per year (for fellows, RN, NP, PAs) or \$67.50 for both memberships in TMEDA and TGS.

**TOTAL AMOUNT ENCLOSED**     \$ \_\_\_\_\_

### **Payment Methods:**

#### **PAYMENT OPTIONS:**

You may go to the Texas Medical Director Association website at [www.tmda.org](http://www.tmda.org) and pay using a credit card which TMEDA will process through our PayPal account.

\_\_\_\_\_ Check enclosed. Please make checks payable to **TMEDA**

### **Credit Card Payments**

\_\_\_\_\_ Visa     \_\_\_\_\_ MasterCard     \_\_\_\_\_ American Express

Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_ Security Code \_\_\_\_\_  
*(THE TRANSACTION PROCESSED THROUGH TMEDA'S PAYPAL ACCOUNT WILL APPEAR ON YOUR CREDIT CARD STATEMENT AS "TEXASMED")*

Signature \_\_\_\_\_ Print Name \_\_\_\_\_  
*(as it appears on the card)*

### **Mailing Payment**

#### **Address:**

**TMEDA**  
c/o LTC Direct, Inc.  
Attn: Cheryl Casey  
11000 Broken Land Parkway, Suite 402  
Columbia, MD 21044

You may also fax the form to 410-740-6649 and mail the check separately.

If you have questions regarding membership, please visit [www.tmda.org](http://www.tmda.org) email [tmdawebsite@gmail.com](mailto:tmdawebsite@gmail.com) or call Cheryl Casey at 410-992-3136.