REQUEST FOR CHANGE TO RETIRED STATUS

Date of Application_____

Name _____

Current Mailing Address _____

City, State, Zip _____

County_____ **Phone (_____)** _____

Preferred Email Address _____

The primary form of communication whenever possible will be by email. Please check the box below if you would prefer your dues statement mailed to you or if you would like to be paperless and receive all statements by email.

☐ Please mail my dues statement to my current mailing address listed above

☐ Please send my statements by **email ONLY**

☐ **I am requesting a change in membership status from Active to Retired.**

Retired Membership is granted to those who are <u>fully</u> retired and no longer see patients for a fee, maintain an office, or derive income from the practice of medicine in any form.

Because WOMA plans its budget around membership dues, ***please let us know as soon as possible, but no later than September 30th***, if you are planning to retire and switch over to the Retired Member rate for the following year.

Please call the WOMA office at 425-677-3930 to discuss your options after September 30th.

" By my signature, I hereby authorize release of the information contained in this application and WOMA membership file to those organizations or hospitals to whom I may subsequently apply for membership; and release to WOMA, by organizations, agencies and hospitals of information relative to my membership in those organizations and my professional practice. I understand that withholding or falsification of information will result in denial of membership."

_____ _____

Member Signature Date