



Mailing Label
Application & Agreement

Renter Info:

Name: _____
Business Name: _____
Business Address: _____

Phone: _____ Fax: _____
E-Mail: _____

Label Lists (√ all that apply):

- | | |
|---|--|
| <input type="checkbox"/> 1. <u>SICMS Practicing Physicians List</u>
SJCMS Members pay \$30/set | <input type="checkbox"/> Alphabetical Order <input type="checkbox"/> Zip Code Order
Non-SJCMS Members pay \$60/set |
| <input type="checkbox"/> 1A. <u>SICMS Retired Physicians List</u> | (Only With the Above Order - at no additional cost) |
| <input type="checkbox"/> 2. <u>SICMS Non-Member Physicians List</u>
SJCMS Members pay \$30/set | <input type="checkbox"/> Alphabetical Order <input type="checkbox"/> Zip Code Order
Order Non-SJCMS Members pay \$60/set |
| <input type="checkbox"/> 3. <u>Master List</u> (Includes List 1 & 2)
SJCMS Members pay \$50/set | <input type="checkbox"/> Alphabetical Order <input type="checkbox"/> Zip Code Order
Order Non-SJCMS Members pay \$100/set |
| <input type="checkbox"/> 4. <u>Special Request</u> (See Attachment)
Order SJCMS Members pay \$40 per set per member type
Non-SJCMS Members pay \$70 per set per member type
<i>Specified By SJCMS-Member Type* (√ one):</i> <input type="checkbox"/> <i>Members</i> <input type="checkbox"/> <i>Non-Members</i>
<i>* An additional \$10 will be added for both Member Types</i> | <input type="checkbox"/> Alphabetical Order <input type="checkbox"/> Zip Code |

Do you want to include Kaiser Permanente & Sutter Gould Doctors? _____
Specified By City(s): _____
Specified By Specialty (Refer to Next Page): _____

Other Specification(s): _____

PLEASE READ AND SIGN

WITHOUT EXCEPTION: All requests **must** include a program brochure or draft copy of material to be mailed. **Payment is due** with this application. I understand that all labels purchased from the San Joaquin Medical Society are for one-time use only.

Signature: _____ Title: _____
Date: _____

SPECIALTIES LIST

CHECK ALL THAT APPLY

**(For Special Request of Label List #4
Only)**

- | | |
|--|--|
| <input type="checkbox"/> ADDICTION MEDICINE | <input type="checkbox"/> ORTHOPEDICS |
| <input type="checkbox"/> ADMINISTRATIVE MEDICINE | <input type="checkbox"/> OTOLARYNGOLOGY |
| <input type="checkbox"/> ADOLESCENT MEDICINE | <input type="checkbox"/> OTOLOGY |
| <input type="checkbox"/> ALLERGY-IMMUNOLOGY | <input type="checkbox"/> PATHOLOGY |
| <input type="checkbox"/> ANESTHESIOLOGY | <input type="checkbox"/> PHYSICAL MED. & REHAB. |
| <input type="checkbox"/> CARDIOLOGY, PEDIATRIC | <input type="checkbox"/> PUBLIC HEALTH/PREVENT. MED. |
| <input type="checkbox"/> CARDIOVASCULAR | <input type="checkbox"/> PULMONARY, CRIT. CARE MED. |
| <input type="checkbox"/> CARDIOVASCULAR DISEASE | <input type="checkbox"/> PULMONARY DISEASES |
| <input type="checkbox"/> DERMATOLOGY | <input type="checkbox"/> PSYCHIATRY |
| <input type="checkbox"/> EMERGENCY MEDICINE | <input type="checkbox"/> RADIOLOGY |
| <input type="checkbox"/> ENDOCRINOLOGY/DIABETES | <input type="checkbox"/> RADIOLOGY, DIAGNOSTIC |
| <input type="checkbox"/> ENDOCRINOLOGY, REPRODUCTIVE | <input type="checkbox"/> RESPIRATORY CARE |
| <input type="checkbox"/> FAMILY PRACTICE | <input type="checkbox"/> RHEUMATOLOGY |
| <input type="checkbox"/> GASTROENTEROLOGY | <input type="checkbox"/> SLEEP MEDICINE |
| <input type="checkbox"/> GENERAL PRACTICE | <input type="checkbox"/> SPORTS MEDICINE |
| <input type="checkbox"/> GENERAL PREVENTIVE MEDICINE | <input type="checkbox"/> SURGERY, ASSIST |
| <input type="checkbox"/> GERIATRIC MEDICINE | <input type="checkbox"/> SURGERY, CARDIOTHORACIC |
| <input type="checkbox"/> GYNECOLOGY | <input type="checkbox"/> SURGERY, CARDIOVASCULAR |
| <input type="checkbox"/> HEMATOLOGY | <input type="checkbox"/> SURGERY, COLON & RECTAL |
| <input type="checkbox"/> HEMATOLOGY/ONCOLOGY | <input type="checkbox"/> SURGERY, GENERAL |
| <input type="checkbox"/> INFECTIOUS DISEASE | <input type="checkbox"/> SURGERY, GENERAL VASCULAR |
| <input type="checkbox"/> INTERNAL MEDICINE | <input type="checkbox"/> SURGERY, HAND |
| <input type="checkbox"/> NEONATAL-PERINATAL MEDICINE | <input type="checkbox"/> SURGERY, HEAD AND NECK |
| <input type="checkbox"/> NEPHROLOGY | <input type="checkbox"/> SURGERY, NEUROLOGICAL |
| <input type="checkbox"/> NEUROLOGY | <input type="checkbox"/> SURGERY, ORAL & MAXILLOFACIAL |
| <input type="checkbox"/> NUCLEAR MEDICINE | <input type="checkbox"/> SURGERY, ORTHOPEDIC |
| <input type="checkbox"/> OBSTETRICS & GYNECOLOGY | <input type="checkbox"/> SURGERY, PLASTIC |
| <input type="checkbox"/> OCCUPATIONAL MEDICINE | <input type="checkbox"/> SURGERY, PLASTIC & RECONSTRUCT. |
| <input type="checkbox"/> ONCOLOGY, GYNECOLOGY | <input type="checkbox"/> SURGERY, THORACIC |
| <input type="checkbox"/> ONCOLOGY, RADIATION | <input type="checkbox"/> UROLOGY |
| <input type="checkbox"/> OPHTHALMOLOGY | |