

APPLICATION FORM

Please complete this form for submission to Medical Tourism Association® Mail: 4371 Northlake Blvd., Suite 307 Palm Beach Gardens, FL 33410 Fax to: (866) 756-0811

Organizati	on Name	
(For Listing) Address		
Postal Cod	de City	State
Country _		
Main Tele _l	phone Fax	
Main Ema	il Website	
Name Applicant	Title	E - mail
CEO		
Billing Contact _		
Email to r	eceive all MTA correspondences	
	Please Check the Application Level you are app	lying for:
	Elite Membership	\$25,000 - \$40,000 □
	Corporate Gold (Includes Premiere Benefits)	\$5,000 □
	Government/Healthcare Cluster	\$5,000 □
	Hospital/Specialty Clinic/Wellness	\$3,000
	Facilitator *Certified Medical Tourism Specialist® (CMTS) or *Certified Medical Tourism Professional® (CMTP) Included	\$2,500 □
	Corporate/Travel and Hospitality Companies	\$1,500 🗆
	Certified Medical Tourism Specialist® or Certified Medical Tourism Professional® (CMTS/CMTP)	\$1,500 □
	☐ Yes, include me on MTA Directory and MTA Website List ☐ No, exclude me from MTA Directory MTA Website Listin	-

If for any reason membership cannot be granted then a refund of the membership dues will be sent to the applicant.

www.MedicalTourismAssociation.com info@MedicalTourismAssociation.com US (561) 791-2000



Member Name:					
Billing Address:					
City:		State:	Zip:		
Country:					
Phone:					
Email:					
By submitting this agreement, I am authorizing the Medical Tourism Association® to bill my credit card. All inquiries and requests must be submitted in writing and mailed to the MTA: Medical Tourism Association®					
4371 Northlake Blvd., Suite 307 Palm Beach Gardens, FL 33410					
By signing below I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize the MTA to charge my credit card for my dues annually. MTA will, in turn, provide me with a receipt detailing the charges. It is my responsibility to notify the MTA of any change in my demographic information that would prevent me from receiving material from the MTA. I further agree that in the event my credit card becomes invalid, I will provide the MTA with a new valid credit card, to be charged for the payment of any outstanding balances owed to the MTA.					
Signature		Email:			
CREDIT CARD BILLING INFORMATION					
Please Circle One: Visa	MasterCard	Discover	American Express		
Credit Card Number:					
Expiration Date:	CVV Code:				
Name on Credit Card	:				
Authorized Signature	i:				