



2010/2011 Medical-Legal Handbook Order Form

Date: _____

Physician's Name: _____

Mailing Address (No P.O. Boxes): _____

City, State, Zip _____

<u>Select one:</u>	<u>Price</u>	<u>Quantity</u>	<u>*Total</u>
OMA Member	\$74.95	_____	_____
Non-OMA Member	\$649.95	_____	_____

** Price includes shipping & handling*

Check one: _____ Check _____ Mastercard _____ Visa _____

Account Number: _____ Exp. Date: _____

Name on Card: _____

_____ \$ _____

Cardholder Signature _____ Total Amount _____

PLEASE NOTE THAT ALL ORDERS MUST BE PREPAID.

Return form with check or credit card information to: Oregon Medical Association OR Fax #: 503-619-0609 Attn: Kimberly Weitman 11740 SW 68 th Parkway, Suite 100 Portland, OR, 97223	For OMA use only: Member #: _____ Received: _____ S/O: _____
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