MMDA Membership Form

Access to members-only sections of our website providing the following:

- CMS' memo on delegation of visits to NPs and PAs in the subacute and LTC units of a facility
- Quick access to OHCQ's Transmittals and Clinical Alerts
- Easy, quick access to MOLST information and forms
- Accesss to minutes of business meetings
- State legislative information
- Quick download of memos from CMS on specific topics, such as the memo in 2014 on CPR in nursing homes
- Easy access and link to CMS Nursing Home Compare and Physician Compare
- Best practices: Dementia care, DHMH infection prevention information
- Link to CMS' website for Open Payments
- Leadership, education, and advocacy on federal and state-level issues affecting our patients, residents, colleagues and community
- CEUs for physicians, APNs, and medical directors
- Discounted registration fee for members

You can register to become a member or renew your MMDA membership online. Our membership year begins every January 1 and ends on December 31 of the same calendar year. Payment of dues applies to the calendar year when the payment is received, except during the 3 month period prior to January 1. Dues paid during the 3 months prior to the following date of January 1 will be applied to the coming calendar year. For example, paying dues on October 1, will provide membership for 1/1/xx – 12/31/xx. However, payment of dues on September 30, or before will provide membership for the prior yearPlease complete the fields in the membership application below and then click on the submit button. After you successfully submit

your application, please return to this page to make your online payment for your membership using the secure PayPal system. If you have any questions about membership, please contact MMDA at mmdawebsite@gmail.com.Please submit payment using PayPal's secure system, then complete this membership application. You will receive an e-mail confirmation that your application has been received. Please allow 3-5 business days for MMDA to contact you with additional membership information. Print and mail in the Application.

Please enable JavaScript in your browser to complete this form.
Name *
First
Last
Credential(s)
Affiliation
Address
Address Line 1
Address Line 2
City
--- Select state --- State
Zip Code
Email *
Phone *
Fax
Number of years I have served as a Medical Director
Number of years I have served as a clinician in long-term care (copy)
I am interested in working on the following committee(s) – Each are for 1-year terms.

- ☐Quality Assurance/Patient Care
- ☐Education/Program
- ☐Finance
- ☐Public Policy
- ☐Membership

Membership Term

- ○1-Year
- ○2-Year

Payment Method *

- ○Check
- ○Credit Card

Total
$0.00
Stripe Credit Card *

Submit