



馬來西亞中醫總會®
馬來西亞中醫師公會®



MALAYSIAN CHINESE MEDICAL ASSOCIATION
PERSATUAN TABIB TIONGHUA MALAYSIA (PPM-009-14-18121953)

No: 16&18, Jalan Brunei Barat, Off Jalan Pudu, 55100 Kuala Lumpur.

Tel: 03-21421263, 21420263, Fax: 03-21422118.

E-mail: admin@mcma.com.my

入会志愿书

本人 _____, 发誓所呈文件决无虚假, 并已详阅会员守则, 了解会员权益, 赞同贵会之宗旨, 並愿绝对遵守总会章程, 若有违反总会章程或会员守则, 愿受调查与制裁。兹特申请加入贵会为 普通会员 永久会员 附属会员

(附属会员: 外国医师会员 传统治疗师会员 文凭会员

学生会员 中药行业会员 大马技术证书会员)

(请详阅背页“申请会员条规”), 谨填履历表, 敬祈批准为荷。

敬致

马来西亚中医总会理事会

签名: _____

年 月 日 立志愿书人: (_____)

MEMBERSHIP LETTER OF CONSENT

I hereby certify that the below statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits.

I have read and agreed to abide by the terms and conditions as provided in the Constitution of Malaysian Chinese Medical Association (MCMA). I understand that any violation of the aforesaid terms and conditions may result in the revocation of my membership and/or disciplinary action may be taken.

Hereby I wish to join the Association as:

Ordinary Member Life member Affiliate member

Affiliate member includes:

Overseas member Traditional Medicine Practitioner Certificate member

Student member TCM Industry Personnel Member Sijil Kemahiran Malaysia member

DATE: _____

(SIGNATURE OF APPLICANT)

NAME OF APPLICANT:

相 片	申请者履历表 APPLICANT RESUME			
	中文姓名			
	NAME			
	性别 GENDER		年龄 AGE	
	国籍 NATIONALITY	<input type="checkbox"/> 马来西亚 MALAYSIAN	<input type="checkbox"/> 其他 OTHERS:	_____
身份证号码 IDENTITY CARD No.				
证件号码 (非马来西亚国籍) PASSPORT No. (For Non-Malaysian)				
手机号码 MOBILE PHONE No.				
电邮地址 EMAIL ADDRESS				
出生日期 BIRTH DATE		出生地点 BIRTH PLACE		
通讯处 MAILING ADDRESS				
永久通讯处 PERMANENT MAILING ADDRESS				
学术专业资格 ACADEMIC QUALIFICATIONS (可多项选择 MAY TICK MORE THAN ONE) <input type="checkbox"/> 祖传/师承 APPRENTICESHIP <input type="checkbox"/> 中医文凭 DIPLOMA/CERTIFICATE OF TRADITIONAL CHINESE MEDICINE <input type="checkbox"/> 中医学士学位 BACHELOR DEGREE OF TRADITIONAL CHINESE MEDICINE <input type="checkbox"/> 中医硕士学位 MASTER OF TRADITIONAL CHINESE MEDICINE <input type="checkbox"/> 中医博士学位 PHD OF TRADITIONAL CHINESE MEDICINE <input type="checkbox"/> 其他 OTHERS : _____				
目前工作单位名称 COMPANY NAME				
职称 DESIGNATION				
目前工作单位地址 COMPANY ADDRESS				
目前工作单位电话 COMPANY CONTACT No.				
主治 PROFESSION	<input type="checkbox"/> 内科 INTERNAL MEDICINE	<input type="checkbox"/> 针灸 ACUPUNCTURE	<input type="checkbox"/> 推拿 TUINA	
接受信息的方式 METHOD OF RECEIVING MESSAGE	<input type="checkbox"/> 微信 WECHAT : _____ <input type="checkbox"/> 信函 LETTER : _____ <input type="checkbox"/> 电邮 EMAIL : _____			
行医年数 YEARS OF PRACTICE				
备注: 有意申请本会中医师证者, 请打勾 () () Please tick if you interested to apply Sijil Keanggotaan Perubatan Tradisional Cina from MCMA.				

证书号 _____
行医证号 _____

会长: _____