The Physician Advocacy Liaison Network
Register Below:

First Name: _____ Last Name: _____

Credentials: _____ Email: _____

Cell Phone: _____ Office Phone: _____

If you live outside of NY, please check here ☐ and provide your practice address which is in NY. Otherwise, provide your voting address (where you live).

Voting Street Address: _____

Voting Town/City: _____

Voting Zip Code: _____

County where you live: _____

County where you are a medical society member, if different: _____

Specialty: _____

Practice Environment: (employed hospitalist, private solo practice, multi-specialty group, etc)

_____

_____

Do you already have a relationship with a state-level legislator? If so, please list

_____

_____

If you do not already have a personal relationship with a legislator, are you willing to become a key contact for a legislator where you live (and vote)?

_____

_____

Are you a member of PAC?

☐ YES

☐ NO, but I would like more information

Please check here: ☐ I understand that the information provided herein will be kept confidential. I give MSSNY permission to contact me on the topic of PAL (Physician Advocacy Liaison), PAC (Political Action Committee), GAC (Grassroots Action Center) and Governmental Affairs matters, even if I have opted out of other MSSNY mailing types in the past. Initial Here: _____.

Return to Carrie Harring at charring@mssny.org. Thank you.