

MEMBERSHIP APPLICATION

For North American Residents

Name: _____

Title MD DO

Office Address: _____

Home Address: _____

Preferred Mailing Address: Office Home

Office Phone: _____

Home Phone: _____

Fax: _____

E-Mail: _____

Preferred Communication: Mail _____ E-Mail _____ Fax _____

Date of Birth: _____

Sex: Male _____ Female _____

Medical School Graduation Year: _____ Degree Received: _____

Residency Institution and Date of Completion _____

Fellowship, Institution, and Date of Completion: _____

Membership

- Physician (Dues - \$200, Annually)
- Resident (Dues - \$100, Annually)
- Student (Dues - \$25, Annually)
- Other (Nurse, EMT, etc.) (Dues - \$25, Annually) Occupation: _____
- Life Member (Dues - \$800, One Time)

Applicant's Signature _____ Date _____

Please return this completed form with payment

Please make check payable to: AAEMI, Treasurer

Please mail to: AAEMI, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105-8820