

# MEMBERSHIP APPLICATION

For **INDIAN RESIDENTS**

Name: \_\_\_\_\_

Title MBBS MD MS MCH DIPNB OTHER

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 College Graduation Year: \_\_\_\_\_ Degree Received: \_\_\_\_\_

Residency Institution (PG) and Date of Completion \_\_\_\_\_

Fellowship, Institution, and Date of Completion: \_\_\_\_\_

## **Membership**

- Physician (Dues - \$75, Annually)
- Post Graduate( Resident )(Dues - \$35, Annually)
- Medical Student (Dues - \$20, Annually)
- Other (Nurse, EMT, etc.) (Dues - \$20, Annually) Occupation: \_\_\_\_\_
- Life Member (Dues - \$300, 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