AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

STUDENT

MEMBERSHIP APPLICATION: Please complete the entire form and return by fax to (913) 906-6088 or mail to AAFP Member Resource Center, AAFP, 11400 Tomahawk Creek Pkwy., Leawood, Kansas 66211-2680.

1. Membership is FREE for students enrolled in allopathic or osteopathic medical schools that are (a) accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association's Commission on Osteopathic College Accreditation (AOA COCA), or (b) listed as operational in the then-current edition of the World Directory of Medical Schools.
2. Student membership terminates upon graduation. If you desire to maintain AAFP membership, you must reapply for resident or transitional membership.

PLEASE PRINT

*NAME _____

☐ MALE ☐ FEMALE ☐ TRANSGENDER ☐ OTHER ☐ PREFER NOT TO ANSWER

FORMER NAME _____ DATE OF BIRTH ____/____/____

*MAILING ADDRESS _____ APT #: _____

*CITY _____ *STATE/PROVINCE _____ *COUNTRY _____ *ZIP _____

*EMAIL _____

(PLEASE NOTE THAT FOR CERTAIN MEMBER BENEFITS, YOU MUST PROVIDE A WORKING EMAIL ADDRESS IN ORDER TO RECEIVE THEM.)

TWITTER HANDLE @ _____

*PHONE _____ ☐ HOME ☐ CELL

*MEDICAL SCHOOL _____ LENGTH OF PROGRAM _____ YRS

(PLEASE DO NOT ABBREVIATE)

CITY _____ *STATE/PROVINCE _____ COUNTRY _____

DEGREE _____

*MEDICAL SCHOOL START DATE ____/____/____ GRADUATION DATE ____/____/____

ARE YOU ACTIVE DUTY MILITARY OR DO YOU HAVE A MILITARY SERVICE OBLIGATION DUE TO A HEALTH PROFESSIONS SCHOLARSHIP?

☐ YES ☐ NO

In signing this application, I certify that the above information is correct and complete and do hereby agree to abide by the bylaws of the American Academy of Family Physicians and the bylaws of my constituent chapter, if applicable. I understand that by providing my mailing address, email address, telephone numbers, and fax number, I consent to receive communications sent by or on behalf of the AAFP and its chapters and affiliates via regular mail, email, telephone, or fax.

*SIGNATURE OF APPLICANT _____ DATE _____

By submitting this application, the applicant authorizes the release of medical education information by the institution identified above to the AAFP for purposes of credential verification.

*REQUIRED