AAFP
STRONG MEDICINE FOR AMERICA

international membership application (Medical Student)

FOR OFFICE USE ONLY

You can also apply for membership online at www.aafp.org/intlapp

ARE YOU A PREVIOUS MEMBER OF THE AAFP? ☐ YES ☐ NO IF YES, PREVIOUS AAFP ID (IF KNOWN)?_____

PERSONAL INFORMATION

NAME (FIRST) _____

(MIDDLE) _____

(LAST) _____ (SUFFIX) _____

(PREVIOUS LAST NAME, IF DIFFERENT) _____

DATE OF BIRTH (MM) _____ (DD) _____ (YYYY) _____

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

STREET ADDRESS _____

_____

CITY _____

STATE _____ ZIP _____

PROVINCE _____ COUNTRY _____

HOME PHONE (_____)_____

PHONE NUMBER(S)

PLEASE INDICATE WITH A CHECK MARK YOUR PREFERRED PHONE NUMBER.

☐ HOME (_____)_____

☐ CELL (_____)_____

EMAIL ADDRESS

EMAIL_____

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

TWITTER HANDLE

TWITTER HANDLE _____@_____

MEDICAL SCHOOL

UNIVERSITY NAME _____
(PLEASE DO NOT ABBREVIATE)

CITY_____

PROVINCE_____

COUNTRY _____

DEGREE (MD, MBBS, ETC.)_____

START DATE_____
(MM/DD/YYYY)

GRADUATION DATE _____
(MM/DD/YYYY)

SIGNATURE/CERTIFICATION

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. 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 subsidiaries and affiliates) via regular mail, email, telephone, or fax.

SIGNATURE _____

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.

PAYMENT

PAYMENT OF DUES IS REQUIRED BEFORE YOUR MEMBERSHIP WILL BE ACTIVATED. TO EXPEDITE YOUR MEMBERSHIP, YOU MAY PAY YOUR MEMBERSHIP DUES BY CREDIT CARD VIA THIS APPLICATION, YOUR CARD WILL BE CHARGED FOR THE FULL AMOUNT OF DUES AT THE ANNUAL RATE OF U.S. $35. IF YOU HAVE ANY QUESTIONS ABOUT THE APPLICATION PROCESS, PLEASE CALL THE AAFP MEMBER RESOURCE CENTER AT (913) 906-6000 OR EMAIL US AT AAFP@AAFP.ORG.

SELECT PAYMENT METHOD

CHECKS MUST BE IN U.S. FUNDS DRAWN ON A U.S. BANK.

☐ CHECK ENCLOSED
☐ AMEX
☐ DISCOVER
☐ MASTERCARD
☐ VISA

CARD # _____

EXPIRATION DATE *(MM/YYYY)*_____

SECURITY CODE/CVV#_____

CARD HOLDER'S NAME _____

CARD HOLDER'S SIGNATURE_____

PLEASE SEND COMPLETED APPLICATION, PAYMENT TO:

American Academy of Family Physicians
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2680
Phone: (913) 906-6000
Fax: (913) 906-6075
www.aafp.org

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