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. Student membership is FREE for medical students who are enrolled in a Liaison Committee on Medical Education (LCME) or the American Osteopathic Association's Commission on Osteopathic College Accreditation (AOA COCA) accredited medical school.

2. Membership terminates upon graduation. If you desire to maintain AAFP membership, you must reapply for resident status.

3. For students attending an international medical school, the AAFP offers a membership option tailored to meet your specific need. Please complete an international application for medical students online at www.aafp.org/intlapp.

**PLEASE PRINT**

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<td>☐ MALE                  ☐ FEMALE                  ☐ TRANSGENDER                  ☐ OTHER                  ☐ PREFER NOT TO ANSWER</td>
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**MAILING ADDRESS** ___________________________________________________  APT #: __________

**CITY** __________________________  **STATE** ______________  **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 __________________________  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. 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** (required) ______________________________________  **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**

For more information, call (800) 274-2237 or visit www.aafp.org/join.