



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. 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

*NAME _____

MALE FEMALE TRANSGENDER OTHER PREFER NOT TO ANSWER

FORMER NAME _____ DATE OF BIRTH _____ / _____ / _____

*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 _____ (PLEASE DO NOT ABBREVIATE) LENGTH OF PROGRAM _____ YRS

CITY _____ STATE _____ COUNTRY _____

DEGREE _____

*MEDICAL SCHOOL START DATE _____ / _____ / _____ GRADUATION DATE _____ / _____ / _____

ARE YOU ACTIVE DUTY MILITARY OR A CURRENT HEALTH PROFESSIONS SCHOLARSHIP RECIPIENT? YES NO

In submitting 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 subsidiaries 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