AMERICAN ASSOCIATION FOR PHYSICIAN LEADERSHIP®

Application for Student Membership

Allopathic, osteopathic students are eligible for membership in the association. Student must be currently enrolled in a medical school in the U.S. or Canada, accredited by the Liaison Committee on Medical Education (LCME) or enrolled in an osteopathic college of medicine accredited by the American Osteopathic Association (AOA) or enrolled in a recognized international equivalent school. **Annual dues are $50**. No examination is required for membership. Please return this completed application along with payment of $50 (U.S. currency) to the address below.

Please type or print clearly or attach your primary business card.

Name ____
FIRST NAME MIDDLE (OPTIONAL) LAST NAME

Pursing: ❒ MD ❒ DO ❒ MBSS Date of Birth: ____________________ Nickname ____________________

CONTACT INFORMATION — *REQUIRED

*Accredited Licensing School ______________________________ Anticipated Gradution Date __________

Address ____

City/State/Zip/Country ____

❒ Please send all correspondence to the above address.

*Phone ____________________ Fax ____________________ *Primary E-mail Address ____________________

TO BETTER SERVE OUR MEMBERS, WE ASK YOU FOR THE FOLLOWING INFORMATION

Gender: ❒ Male ❒ Female

Race or ethnicity: ❒ African-American ❒ American Indian/Alaskan Native ❒ Asian/Pacific Islander ❒ Caucasian ❒ Hispanic
❒ Other ____

Reason for joining ____

Referred by ____

CODE OF CONDUCT

In signing this application, I certify that I meet the requirements for the American Association for Physician Leadership® Membership as stated above and that I have read and agree to the association's Code of Conduct (www.physicianleaders.org/conduct) and that the information contained herein is correct. I understand that misrepresentation or omission of facts is cause for my application to be rejected or future dismissal.

Signature of Applicant ______________________________ Date ____________________

PAYMENT

Charge $50 to my credit card: ❒ Visa ❒ MasterCard ❒ Discover ❒ American Express

Credit Card # ______________________________ Exp. Date __________

Signature on credit card ______________________________ Date __________

❒ Check enclosed (payable to American Association for Physician Leadership®)

400 North Ashley Drive, Suite 400, Tampa, FL 33602-4322 ■ 813.287.2000 800.562.8088 Fax: 813.287.8993
www.physicianleaders.org ■ info@physicianleaders.org