



_____ **Date of Application**

APPLICATION FOR MEDICAL STUDENT MEMBERSHIP

1. **Name:** _____
(Last) (First) (Middle)

2. **Date of Birth:** _____ 3: **Sex:** Male Female
(Month) (Day) (Year)

4. **Mailing Address*:** _____
(Number) (Street)

(City) (State) (Zip Code)

(E-Mail) (Office Telephone) (Fax)

5. **Medical School:** _____

(City) (State)

(Date of Enrollment) (Proposed Date of Graduation)

(Department Chair – Please Print) (Department Chair – Signature)

6. _____
APPLICANT'S SIGNATURE

Note: Annual Dues of \$10.00 must accompany application; \$5.00 after June 30.

- **Name, address, telephone, fax, and e-mail information will appear in the ASA Online Directory.**

Completed form may be mailed or faxed to:

**ASA
520 N. Northwest Highway - Park Ridge, IL 60068-2573
FAX: 847-825-1692**