



\_\_\_\_\_ 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