## AMERICAN MEDICAL STUDENT ASSOCIATION MEMBERSHIP APPLICATION

25050 Riding Plaza Ste 130 Box 632, Chantilly, VA 20152 Phone: (800) 767-2266 Fax: (703) 620-6445 Website: www.amsa.org Email: members@amsa.org



First Name	Middle Name	_Last Name	
City	State	Zip	Country
Cell Phone Number	Home P	hone Number	
Preferred Email Address			
Alternate Email Address			
Gender	Birth Date (mm/dd/yyyy)	Ethnicity	
SCHOOL/SUPPORTING School Attending or Gradua	a INFORMATION ate/Supporting Work		
	)Intended Medical Specialty (if applic		
Current Level of Education:	□ Freshman □ Sophomore □ Junior □ Senior □	M1 🗆 M2 🗆 M3 🗆 M	14 🗆 M5+ 🗆 Post-Bac 🛛 Graduate
Other (e.g., dentistry, nursin	ng, allied health, etc.)		
Referred By (e.g. AMSA pa	artner, other nonprofit, etc.)		
PAYMENT INFORMATIO	ON Please select appropriate membership category: AMS	A will review and adjust as	necessary.
PAYMENT INFORMATIC	ON Please select appropriate membership category; AMS2	A will review and adjust as	necessary.
Domestic Medical M	<b>DN</b> Please select appropriate membership category; AMS2 embership - \$75: Medical students enrolled in or on le ed North American (U.S. and Canada) allopathic or oste	ave of absence from any	LCME or AOA accredited or
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