



# STUDENT

**MEMBERSHIP APPLICATION:** Please complete the entire form and return by fax to (913) 906-6075 or mail to AAFP Member Resource Center, AAFP, 11400 Tomahawk Creek Pkwy., Leawood, KS 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](http://www.aafp.org/intlapp). International student dues are \$35 annually.

## PLEASE PRINT AND COMPLETE ALL REQUESTED INFORMATION

NAME \_\_\_\_\_

EMAIL \_\_\_\_\_

(YOU MUST PROVIDE A WORKING EMAIL ADDRESS IN ORDER TO RECEIVE CERTAIN MEMBER BENEFITS.)

☐ MALE ☐ FEMALE      DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ APT #: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_\_) \_\_\_\_\_

MEDICAL SCHOOL NAME \_\_\_\_\_

(PLEASE DO NOT ABBREVIATE)

CITY \_\_\_\_\_ STATE \_\_\_\_\_

MEDICAL SCHOOL START DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ GRADUATION DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*In signing 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 signing this application, the applicant authorizes the release of medical education information by the institution identified above to the AAFP for purposes of credential verification.