

Student National Medical Association

National Office

snmamain@msn.com

(202) 882-2881

www.snma.org

Office Use Only

Member Number _____

Circle One: New Renewal

Region _____ Date Rec. _____

Amt. Pd. _____

Official Membership Application

Please print. Provide all information requested.

Mailing/Identification Information

Please notify the office any time you have a change of address.

Dr. Ms. Mr. Mrs.

Last _____ First Name _____ M.I. _____

Mailing Address _____ Apt./Rm. _____

City/State _____ *Zip Code* _____

Telephone #1: (_____) _____ Telephone #2/Pager (_____) _____

E-mail Address: _____

Demographic Information

Date of Birth _____ Soc. Sec. No. _____

Marital Status: Single Married Divorced

Ethnic Background (Check one):

- Black/African-American Hispanic/Latino (Non-White) White/Caucasian
 American Indian/Alaskan Native Asian/Pacific Islander Other (Please Specify)

Current Educational/Professional/Career Status

Students: Undergrad Medical Student Name of School _____

Other professional degree program _____

Year of graduation _____ Current Year (circle one): 1st 2nd 3rd 4th 5th

Physicians or other health/education professionals:

Resident/intern Licensed physician Other _____

Membership Fee Schedule (Check one) * Pay national dues only. Do not send chapter dues or any other fees with this application.

The membership period in the SNMA is for the calendar year, November 16 through November 15.

<input type="checkbox"/> Active, <i>medical student</i> 4-year membership (no partial payments will be accepted).....	\$ 60.00
<input type="checkbox"/> Active, continuing, 1-year (5 th yr. + <i>medical student</i> in a <u>continuing program</u> ; must have paid a prior \$60 membership).	\$ 20.00
<input type="checkbox"/> Associate, <i>pre-med. student</i> , 1-year.....	\$ 15.00
<input type="checkbox"/> Physician/Patron, <i>health/education professionals</i> , 1-year.....	\$ 30.00
<input type="checkbox"/> Institution, 1-year.....	\$ 100.00
<input type="checkbox"/> Corporate, 1-year.....	\$ 500.00
<input type="checkbox"/> Life Member: the 1-year payment at your last level of membership, times (x) 20 years, or giver's discretion.....	\$ _____

You may charge your membership: MasterCard Visa

Acct. No.: _____ Exp. Date: _____

Name (Please Print): _____ Signature/Authorization: _____

I hereby apply for membership in the Student National Medical Association and understand that I am eligible to continue my membership as long as I remain within the guidelines of the SNMA Constitution and By-Laws. I am submitting the required membership fee along with this application to the address shown below.

Signature _____ Date _____

Return application by mail to:
STUDENT NATIONAL MEDICAL ASSOCIATION
5113 Georgia Avenue, N.W., Washington, D.C. 20011

Notes: The National Office occasionally sells parts of the SNMA mailing list to our corporate and organizational partners.
Last revision, 12/21/00. Previous versions of this form are obsolete.