(Please print or type)

International Medical Student Membership Application

*Required fields—applications will not be accepted if left blank

Name:_____ Date:_____
Full Legal Name

*Date of Birth:_____ *Gender: ☐ Male ☐ Female
MM/DD/YY

*Home Address:_____

City:_____ State:_____ ZIP:_____ Country:_____

*Personal Email:_____ Institution Email:_____

*Personal Tel:_____ Home Cell Work Tel:_____

International Medical School Information

*Medical School:_____

Medical School Address:_____ Suite No:_____

City:_____ State:_____ ZIP:_____ Country:_____

Date of Enrollment:_____ Anticipated Date of Graduation:_____
MM/YY-MM/YY *MM/YY*

Department Chair Name:_____

Department Chair Signature:_____

☐ I agree with the "Guidelines for the Ethical Practice of Anesthesiology" and subscribe to the "Anesthesia Care Team" statement, available at asahq.org/agreement.

Applicant's Signature:_____ **Date:**_____

Payment Method

Note: Dues must accompany application. Membership is based on a calendar year running from January 1-December 31. Please pay only the amount indicated based on the date of your application. Dues payments are not refundable.

☐ **$10 (USD)** Annual Dues ☐ **$5 (USD)** After July 31

☐ American Express ☐ MasterCard ☐ VISA ☐ Check (*Payable to American Society of Anesthesiologists*)

Total Amount:_____Name on Card:_____

Credit Card Number:_____ Expiration Date:_____Card ID:_____

Signature:_____

Mail payment and completed form to:
American Society of Anesthesiologists
Attn: Accounting
1061 American Lane
Schaumburg, IL 60173-4973

Or fax to: Attn: Membership (847) 825-1692