(Please print or type)

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:_____*

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 of $10 must accompany application; the prorated amount is $5 after July 31.

☐ American Express ☐ MasterCard ☐ VISA ☐ Check (*Payable to American Society of Anesthesiologists*)
If paying by credit card, your card will be charged upon approval of your application.

Total Amount:_____Name on Card:_____

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

Signature:_____

Membership in good standing of the American Society of Anesthesiologists
requires adherence to the ASA "Guidelines for the Ethical Practice of Anesthesiology."

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