

# Application for Medical Student Membership

## PERSONAL INFORMATION (Please print or type)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Full Legal Name)

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ Suite No: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

\*E-mail: \_\_\_\_\_  Do Not Display

\*Tel: \_\_\_\_\_  Do Not Display \*Fax: \_\_\_\_\_  Do Not Display

\* Unless indicated in the "Do Not Display" box, this information will be included in your online directory listing that can be viewed by other ASA members.

## MEDICAL SCHOOL INFORMATION

Medical School: \_\_\_\_\_

Medical School Address: \_\_\_\_\_ Suite No: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Enrollment: \_\_\_\_\_ Anticipated Date of Graduation: \_\_\_\_\_

Department Chair Name: \_\_\_\_\_

Department Chair Signature: \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PAYMENT METHOD

**\$10** Annual Dues  **\$5** After July 31

American Express  MasterCard  VISA

**Note: Dues must accompany application. Dues payments are based on a calendar year. Please pay only the amount indicated based on the date of your application. Dues payments are not refundable.**

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: Membership  
1061 American Lane  
Schaumburg, IL 60173-4973

### Or fax to:

Attn: Membership  
(847) 825-1692

# Invest in yourself.

Thinking of anesthesiology as a career? Membership in the American Society of Anesthesiologists is an investment in your future.



American Society of  
Anesthesiologists® 