Student National Medical Association

National Headquarters
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 <u>all</u> information requested.
Please notify the Membership Department any time you have a change in your contact information.

Contact Information

Last _____ First Name _____ M.I. _____

Mailing Address _____ Apt./Rm. _____

City/State _____ Zip Code _____

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

E-mail Address:_____

Demographics Information

Date of Birth _____ Social Security No. _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced

Ethnicity (*check one*):

□ Black/African-American □ Hispanic/Latino (Non-White) □ White/Caucasian
□ American Indian/Alaskan Native □ Asian/Pacific Islander □ Other (please specify) _____

Educational Status: Check one of the following:

___ Allopathic medical student ___ Osteopathic medical student
___ High school student ___ Undergraduate college student
___ Allied health or health professions student ___ Licensed physician
___ Resident physician ___ Other professional degree _____

Name of the school/program in which you are currently enrolled: _____
Expected year of graduation: _____ Degree expected: _____

Membership Fee Schedule *(check one) * Pay national dues only. <u>Do not</u> 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.

____ Active, *medical student*, 4-year membership (no partial payments will be accepted)…….. $ 60.00
____ Active, continuing, 1-year (5th yr. + *medical student*, in a <u>continuing program</u>; **must** have paid a prior $60 membership). $ 20.00
____ Associate, *pre-health. student*, 1-year…… $ 15.00
____ Associate, *pre-health student*, 2-years …… $ 25.00
____ Physician/Patron, 1-year …….. $ 30.00
____ Institution, 1-year …… $ 100.00
____ Corporate, 1-year …… $ 500.00
____ Life Member: the one-year payment at your last level of membership, times (x) 20 years, or giver's discretion ……$ _____

Are you interested in joining the National Medical Association as a Student Member? □ Yes □ No

Payment Options:

1. Check: Please make all checks payable to the Student National Medical Association
2. Credit Card: [ ] MasterCard [ ] Visa [ ] Discover Exp. Date: _____

Acct. No.: _____ Name on card (*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 _____

Please return application to: **Student National Medical Association * 5113 Georgia Avenue, NW * Washington, DC 20011**

Please also provide the information requested on the reverse side of this form.

Please assist us in learning more about our members, so that we can better serve you. Complete the information below and return the completed form, along with your membership payment to the SNMA National Headquarters, at the address shown below.

Thank you!

SNMA Educational & Professional Demographics

Undergraduates or post-graduates
(Associate members)

What is your intended area of study?

___ Allopathic medicine
___ Alternative/Complementary medicine
___ Chiropractic
___ Dentistry
___ Nursing
___ Optometry
___ Osteopathic medicine
___ Pharmacy
___ Physician Assistant
___ Podiatry
___ Public Health
___ Undecided
___ Veterinary medicine
___ MD(DO)/PhD
___ MD(DO)/JD
___ MD(DO)/MPH
___ MD(DO)/MBA
___ Other _____

Medical Students:
(Active members)

What is your intended specialty?
(*Please check an item from the column on the right* >>>>>>>>>>>>>>>>>>>>>>>):

Physicians and other health/education professionals:
(Physician/patron, Institutional, and *Corporate members*)

- Where did you receive your primary professional training?

_____

- Degree program(s) completed (*circle*):

MS/MA MPH MD DO PhD Dual Degree
MBA JD Other ____

- How are you presently employed, what is primary activity ?

___ Clinical practice
___ Research
___ Administration
___ Retired
___ Active military duty
___ Residency/Fellowship
___ Other _____

___ Aerospace Medicine
___ Anesthesiology
___ Allergy & Immunology
___ Basic Science
___ Cardiology
___ Critical Care
___ Dermatology
___ Emergency Medicine
___ Endocrinology
___ Family Practice
___ Gastroenterology
___ General Medicine
___ Internal Med.
___ Geriatrics
___ Hematology/Oncology
___ Infectious Diseases
___ Medical Genetics
___ Nephrology
___ Neurology
___ Neurosurgery
___ OB/GYN
___ Ophthalmology
___ Orthopedics
___ Osteopathic & Manip-ulative Therapy
___ Otolaryngology
___ Pathology
___ Pediatrics
___ Physical Med. & Rehab.
___ Physician scientist
___ Plastic Surgery
___ Psychiatry
___ Public Health
___ Pulmonology
___ Radiology
___ Rheumatology
___ Sports Medicine
___ Surgery
___ Urology
___ Other/Undecided _____

All Respondents:

- How did you first learn about SNMA?

___ Friend/student/colleague
___ teacher/school official)
___ SNMA publication
___ SNMA-sponsored program
___ internet search (SNMA web site)
___ National Convention
___ Regional program
___ local chapter event
___ other

- Have you ever participated in a medical education "pipeline" program? If so, which of the following?:

___ YSEP (SNMA)
___ HPREP (SNMA)
___ MMEP
___ HCOP
___ MAPS
___ Other

Note: The SNMA National Headquarters occasionally sells portions of the SNMA mailing list to our corporate and organizational partners.

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