



MEMBERSHIP APPLICATION

Complete form and return to: Director@amifasintl.org

If paying by check, mail form and check to:

AMIFAS c/o Ann Dosen
 PO Box 1083
 Chapin, SC 29036

FIRST NAME _____

LAST NAME _____

DEGREE (DPM, MD, ETC.) _____

ADDRESS OFFICE HOME _____

ADDRESS LINE 2 _____

CITY _____

STATE, ZIP, COUNTRY _____

EMAIL ADDRESS _____

PRACTICE SETTING HOSPITAL MULTI-SPECIALTY GROUP PRIVATE PRACTICE OTHER _____

OFFICE PHONE _____

MOBILE PHONE _____

PRE-MED COLLEGE/UNIVERSITY _____

MEDICAL SCHOOL NAME _____

MEDICAL – DEGREE EARNED _____

MEDICAL SCHOOL – GRAD YEAR _____

POST-GRAD INTERNSHIPS, RESIDENCY, FELLOWSHIP NAME _____

MIS SURGICAL EXPERIENCE LESS THAN 5 YEARS 5-10 YEARS MORE THAN 10 YEARS _____

STATE LICENSE & NUMBER (1) _____

STATE LICENSE & NUMBER (2) _____

ARE YOU A CURRENT AMIFAS FELLOW? YES NO UNSURE _____

PAYMENT METHOD CHECK ENCLOSED CREDIT CARD _____

CARD NUMBER _____

EXP DATE _____

CVV CODE _____

BILLING ZIP CODE _____

NAME ON CARD _____

<u>TERM OPTIONS</u>	<u>SELECT</u>
ONE-YEAR: <input type="checkbox"/> USA \$495 <input type="checkbox"/> INTERNATIONAL \$250	<input type="checkbox"/>
TWO-YEAR \$749 (USA ONLY) SAVE \$241!	<input type="checkbox"/>
THREE-YEAR \$999 (USA ONLY) SAVE \$486 – BEST VALUE!	<input type="checkbox"/>
<input type="checkbox"/> STUDENT <input type="checkbox"/> RESIDENT (NO CHARGE; REQUIRES VERIFICATION)	<input type="checkbox"/>

RETIRED \$100

By signing this form, I am authorizing AMIFAS to charge the card for the amount indicated above.

 Signature

Date: _____

Questions? Call Ann at (800) 479-4936 or email Director@amifasintl.org