RESIDENT MEMBERSHIP APPLICATION

Name: ______________________________________Degree (s):_______________________D.O.B.____________

Primary Address:________________________________City:______________State:__________Zip:___________

Primary Phone:_______________________________Email:____

Licensed States and Number:_________________________Specialty:___________________________________

Reason for Joining:____Gender: ☐ M ☐ F

Interest Categories:

- ☐ Bioethics & Medical Education
- ☐ Emergency & Disaster Medicine
- ☐ Medicine & Medical Subspecialties
- ☐ Mental Health
- ☐ Public Health & Environment Medicine
- ☐ Quality Care, Patient Safety, & Best Practices
- ☐ Surgery and Surgical Subspecialties
- ☐ Women's & Children Health

Other:____

Communication Preference Opt-In

I Authorize SMA to contact me through the following channels

- ☐ Text (Urgent Updates, New CME and SMJ Updates)
- ☐ Email (Newsletters, Invoices, Promotions)
- ☐ Phone
- ☐ Mail
- ☐ Fax

Education Profile

Medical School:____

Graduation Date (MM/DD/YYYY):____

Name of Residency Program:____

Residency Director's Name:____

End of Residency Date (MM/DD/YYYY):____

SMA Resident Membership (One Year) $50.00

☐ Check (Made payable to SMA) ☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX

Payment Information:

Name as it appears on card:_____________________________Signature:________________________________

Card Number:_____________________________________Expiration date:_____________Security Code:______

☐ Billing Address is the same as the Primary Address listed above.

Billing Address:________________________________City:______________State:__________Zip:___________

Billing Phone:_______________________________Billing Email:____

Joining Members Please Note!

You have 31 days from your joining date to take advantage of the $150,000 of Term Life and $1000 Long-Term Disability benefits without evidence of insurability as long as you are under the age of 65 and working full time.

☐ Check here if you would like to apply.