IDAHO MEDICAL ASSOCIATION
MEDICAL STUDENT MEMBERSHIP APPLICATION

Date: _____

Name:_____ **Male** **Female**
(Last) **(First)** **(Middle)**

Teaching Site:_____ _____
Telephone No.

Address_____
(Where you wish to receive your mail)

Home:_____ _____
(Street) **(City, State, Zip)** **Home Telephone No.**

E-Mail Address_____

Birth:_____ _____ **Spouse:** _____
(Date) **(Place)**

Medical School:_____ **MS1, MS2, MS3, MS4, MS5**
(School/Location) **(Medical School Year)**

Specialty:_____

_____ _____
(Printed/Typed Name) **(Applicant's Signature)**

Idaho Medical Association Membership Dues ..... Waived

Membership year runs from January 1st-December 31st

SEND COMPLETED APPLICATION TO:

IDAHO MEDICAL ASSOCIATION
P.O. BOX 2668
BOISE, ID 83701
PHONE: 208-344-7888
FAX: 208-344-7903