Medical Student Application

Please Type or Print

□ **Male** □ **Female** **Birth Date** _______________ **Country of Birth** _____

First Name _____ **Middle** _____ **Last** _____

Suffix (Jr., II, etc.) _____ **Maiden Name (if applicable)** _____

Preferred Mailing Address _____

City _____ **State** _____ **Zip** _____

Is Preferred Mailing Address □ **Home** □ **Office** □ **Other** _____

Primary Email _____

Cell Phone (_____) _____ **Home Phone (_____)** _____

Medical School _____ **Expected Completion Year** _____

Undergraduate College/University _____ **Graduation Year** _____

I hereby apply for student membership in the Wayne County Medical Society of Southeast Michigan, the Michigan State Medical Society, and the American Medical Association. I certify that I am a duly enrolled student at the Medical School stated in my application above, and that I agree to be governed by the Constitution and Bylaws of each organization. As part of a physician organization committed to strengthening the ethics of medicine, every AMA member pledges to uphold the Principles of Medical Ethics as interpreted in the Code of Medical Ethics (www.ama-assn.org/go/codeofmedicalethics.com), and to comply with the Bylaws of the American Medical Association and the Rules of the AMA Council on Ethical and Judicial Affairs (www.ama-assn.org/go/ceja). Applicants and members of the AMA are required to disclose to the AMA Office of General Counsel any violations or alleged violations of the Principles of Medical Ethics or unprofessional conduct, including actions taken or pending regarding professional licensure, medical staff privileges, or felony or fraud convictions. Additionally, the Health Care Quality Improvement Act requires professional societies (such as the AMA) to report certain professional review actions, including denial of membership, to the National Practitioner Data Bank.

Signature _____ **Date of Application** _______________

□ Dues for 4 Years: $88 □ Dues for 3 Years: $74 □ Dues for 2 Years: $58 □ Dues for 1 Year: $40

□ Check enclosed, payable to MICHIGAN STATE MEDICAL SOCIETY Check # _____

□ Visa □ MasterCard □ American Express □ Discover

Card # _____ Expiration Date _______________

Name as it Appears on Card # _____

Billing address: _____

City _____ State _____ Zip _____

Authorized Signature _____ Date _______________

NOTE: Credit card payments will show two separate charges to equaling the total above: one portion from MSMS, the other from AMA.

Please mail application to:
MSMS | 120 West Saginaw Street | East Lansing, MI 48823 OR Fax to: 517-336-5797