American Naturopathic Medical Association

APPLICATION FOR MEMBERSHIP: **DATE:**_____

NAME:_____ Phone:( )_____

Signature:_____

Address:_____

City:_____State:_____Zip:_____

Birth Date:_____ SS#_____ Citizenship:_____

Bus.Address:_____

City:_____State:_____Zip:_____ Phone:( )_____

Mailing Address: **Check One** ☐Home ☐Business ***Email Address:**_____

EDUCATION:

School:	**Address**	**From/To**	**Degrees**	**Date**

INTERNSHIP/RESIDENCIES: (If applicable)

Location Date

Location Date

CERTIFICATION(S): (If applicable)

Board Date

Board Date

LICENSING:

Type	County/State	Date	No.

It is my desire to become a member of the American Naturopathic Medical Association and I hereby make application for inclusion in the ANMA membership.
Name as you wish it to appear on certificate (Name Only)_____
Payment of $350/$295 in check or money order, must accompany application. Refund made if membership not accepted. Canadian residents must submit comparable amount to U.S. currency.

MC/VISA/DIS#_____Exp.Date:_____VCode#_____
(The V code is the 3 digit code found on back of credit card)

Signature:_____

☐ Professional\Associate membership-$350.00 ☐ Supporting membership - $295.00
☐ Retired/Student membership-$295.00