ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

Japan Resident/Fellow Member Application

AS7165-15

To apply for membership:
1. Complete and sign application below.
2. Enclose your dues payable to: ACP (or include credit card information on the application) and return by fax or mail.

Applicant Contact Information

Last First MI

☐ Dept. ☐ Suite ☐ Apt ☐ Post Office Box ☐ Private Mail Box

Street Address

City Zip/Postal Code

Country Mailing Address: ☐ Home ☐ Office

☐ Please check here if you wish to be excluded from non-ACP–related mailings.

Applicant's ACP # (if known) ☐☐☐☐☐☐☐☐☐☐

Code:

Date of Birth ☐☐ ☐☐ ☐☐
Month Day Year

Daytime Phone

Cell Phone

Preferred E-mail Address
(Required for immediate access to online member benefits including journals)

Other surname used professionally
(To assist in verifying information)

Medical Education

Name of Medical School	City	Country	Year Graduated	Degree Earned
例）The University of Tokyo	Tokyo	Japan	20××	MD

Resident/Fellow Membership is limited to physicians accepted into accredited residency training programs in internal medicine, combined internal medicine programs, neurology, or fellowships in a subspecialty of internal medicine (may include physicians with MBBS pursuing MD).

Present Position/Institution/City Example: Resident/Tokyo Hospital/Tokyo	**PG Year** Example: Training Year 1	**Training Starts** Example: 7/20
Resident, ×× Hospital	Training Year 3	3/12

Office Use Only:Internal Medicine Residency Program Number

Sponsor

上司の先生のお名前
Print Name of Program Director

Program director's signature verifies that the applicant is now in internal medicine or its subspecialty training program as detailed in the application attachment. Applicant authorizes ACP to obtain updated contact information from training program.

上司の先生のご署名 日付
Signature of Program Director **(Required)** Date

（空欄） （空欄）
Signature ACP Governor of Japan **(Required)** Date

（空欄）
Recommended Term Year

I am now in training, and I intend to become a Fellow of the Japanese Society of Internal Medicine (JSIM) . I will inform the Japan Chapter in writing if I transfer to other specialties. I understand that I will lose the eligibility as a Resident/Fellow Member in such case.

Sign Here

ご署名 日付
Signature of Applicant **(Required)** Date

PLEASE DO NOT DETACH.

PAYMENT REQUIRED WITH APPLICATION

Send application with payment to:
ACP Japan Chapter
5-11-1-1201 Toranomon, Minato-ku
Tokyo 105-0001
JAPAN
E-mail: office@acpjapan.org

お名前（英字ブロック体）
Full Name of Applicant (Please Print)

☐ $49 USD (online publications only). For membership July 1, 2018 through June 30, 2019 .

ACP USE ONLY

☐ **Check enclosed.** Must make payable to ACP, and remit in U.S. funds drawn on a U.S. bank.

☐ **Charge dues to:**
☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Card # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date ___/___ Security Code 3－4桁の数字

Signature ご署名
Required