

Please complete and sign the application below to apply for your **FREE ACP Medical Student Membership**.

Applicant Contact Information (all fields required)

Last _____ First _____ MI _____

Street and Number _____

City _____ State/Province _____

ZIP/Postal _____ 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 (required)
Month Day Year

Daytime Phone _____

Daytime Fax _____

Cell Phone _____

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

Medical School

Only students enrolled in a medical school included in the World Directory of Medical Schools (www.wdoms.org) are eligible.

Name of Medical School	City	State/Province	Country	Anticipated Graduation Year	Anticipated Degree

SIGNATURE OF APPLICANT: I affirm that I am currently a medical student enrolled in a medical school included in the World Directory of Medical Schools (www.wdoms.org) and that I have not been the subject of disciplinary action.*

* Check here if you have been subject to disciplinary action, and attach a detailed explanation, including current status, of any issue(s).

Sign Here 

Signature of Applicant (**Required**) _____

Date _____

Applicant Please Note: The following information will help provide ACP with accurate membership statistical data but will not be considered in connection with your application for Medical Student membership. Completion is optional.

Gender:

- Male
- Female
- Elect not to specify

Ethnicity:

- White, not of Hispanic origin (1)
- African/African American (2)
- Asian/Asian American (3)

- Arab (4)
- Hispanic (5)
- Indian (I)
- Pakistani (P)

- Native American/Alaskan Native (7)
- Pacific Islander (8)
- Other (9)
- Elect not to specify (E)

For medical students in the United States:

Current Military Rank: _____

I wish to be part of the following U.S. Armed Forces ACP Chapter:

- U.S. Army
- U.S. Air Force
- U.S. Navy

Completed applications should be mailed to:

American College Of Physicians
Member Credentialing
190 N Independence Mall West
Philadelphia, PA 19106-9855