American College of Physicians
Leading Internal Medicine, Improving Lives

Medical Student Membership Application

AS6135-7

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

Applicant Contact Informationn (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
例）University of Tokyo	Tokyo	Tokyo	Japan	20××（卒業予定年）	MD

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 御署名 日付

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