

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

Applicant Contact Information

Last First MI

Dept. Suite Apt. Post Office Box Private Mailbox

Street Address

City State ZIP +4

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)

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

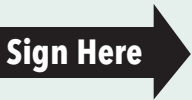
Medical School

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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).



Signature of Applicant (Required) _____

Date _____

Completed applications should be mailed to:

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