



Student National Medical Association
Official Membership Application

Please notify SNMA of any changes in contact info
202-882-2881 snma@snma.org www.snma.org

Office Use Only
Member Number
Circle One: New Renewal
Region Date Rec.
Amt. Pd.

Have you previously paid SNMA national dues? Yes (Renewal) No (New Member)

Contact Information

First Name Middle Initial Last Name Suffix/Degree
Street Address City State Zip Code
Telephone #1 Telephone #2 E-mail (print neatly)

Educational Status:

Current School/Institution (please no abbreviations) City, State Graduation year

Current/Expected Degree(s) (check all that apply):

B.S. B.A. M.A. M.S. M.P.H. M.B.A. M.D. D.O. Ph.D. J.D. Other(s) (specify)

Check all that apply:

Medical student Graduate student Undergraduate/Post-bac student High school student
Allied health or health professions student Graduate student Licensed physician Resident/Fellow

Membership Fee Schedule (check only one)

Pay national dues only. Do not send chapter dues or any other fees with this application. The membership period in the SNMA is for the calendar year, November 16 through November 15.

- Active, 4-year, medical students, residents, fellows, (no partial payments will be accepted) \$ 60.00
Active, 1-year continuing, (5+ years; must have paid a prior \$60 membership) \$ 20.00
Associate, 1-year undergrad/grad/post-bac student \$ 15.00
Associate, 2-year undergrad/grad/post-bac student \$ 25.00
Physician/Patron, 1-year \$ 30.00
Institution, 1-year \$ 100.00
Corporate, 1-year \$ 500.00
Life Member: the one-year payment at your last level of membership multiplied by 20 years or greater donation) \$

Payment Options:

Check: Please make all checks payable to the Student National Medical Association
Credit Card: [] MasterCard [] Visa [] Discover Exp. Date
Acct. No.: Security code (back of card)
Name on Card (print neatly) Signature/Authorization:

Demographic information (optional)

Age: 17-20 21-25 26-30 31-35 36-40 50+
Race (check one that most identifies you): Black (non-Hispanic) Latino/Hispanic Asian/Pacific Islander
Native American Caucasian Other (please specify)
Gender: M F Marital Status: Single Married Divorced

Please read, check, and sign to complete application

I hereby apply for membership in the Student National Medical Association and understand that I am eligible to continue my membership as long as I remain within the guidelines of the SNMA Constitution and By-Laws. I am submitting the appropriate and required membership dues along with this application to the address shown below.

Signature Date

Please return application and dues to:

SNMA National Headquarters * 5113 Georgia Avenue, NW * Washington, DC 20011 * (202) 882-2881
New Members - Please provide the information requested on the reverse side of this form.





SNMA New Member Survey

Please assist us in learning more about our members, so that we can better serve you. Complete the information below and return the completed form, along with your membership payment to the SNMA National Headquarters, at the address shown below. Thank you!

SNMA Educational & Professional Demographics

Undergraduates or post-graduates (Associate members): What is your intended area of study? (check all that apply)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Allopathic medicine | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> MD (DO)/JD |
| <input type="checkbox"/> Osteopathic medicine | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> MD (DO)/PhD |
| <input type="checkbox"/> Veterinary medicine | <input type="checkbox"/> Nursing | <input type="checkbox"/> MD (DO)/MPH |
| <input type="checkbox"/> Alternative/Complementary med | <input type="checkbox"/> Public Health | <input type="checkbox"/> MD (DO)/MBA |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Dentistry | <input type="checkbox"/> Undecided |
| <input type="checkbox"/> Podiatry | <input type="checkbox"/> Optometry | <input type="checkbox"/> Other _____ |

Medical Students: What is your intended specialty?

- | | | |
|---|--|---|
| <input type="checkbox"/> Aerospace Medicine | <input type="checkbox"/> Family Practice | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Neurosurgery |
| <input type="checkbox"/> Allergy & Immunology | <input type="checkbox"/> General Medicine | <input type="checkbox"/> OB/GYN |
| <input type="checkbox"/> Basic Science | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Osteopathic Manipulative Therapy |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Infectious Diseases | |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Medical Genetics | |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Nephrology | |

Physicians and other health/education professionals (Physician/patron, Institutional, and Corporate members):

Where did you receive your primary professional training?

_____ Medical School (no abbreviations please)

Degree program(s) completed:

- | | |
|---------------------------------|---|
| <input type="checkbox"/> M.A. | <input type="checkbox"/> D.O. |
| <input type="checkbox"/> M.S. | <input type="checkbox"/> Ph.D. |
| <input type="checkbox"/> M.P.H. | <input type="checkbox"/> J.D. |
| <input type="checkbox"/> M.B.A. | <input type="checkbox"/> Other(s) (specify) _____ |
| <input type="checkbox"/> M.D. | |

How are you presently employed? What is your primary activity?

- | | |
|--|---|
| <input type="checkbox"/> Clinical practice | <input type="checkbox"/> Active military duty |
| <input type="checkbox"/> Research | <input type="checkbox"/> Residency/Fellowship |
| <input type="checkbox"/> Administration | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Retired | |

All Respondents: - How did you first learn about SNMA?

- | | |
|---|--|
| <input type="checkbox"/> Friend/student/colleague | <input type="checkbox"/> local chapter event |
| <input type="checkbox"/> National Convention | <input type="checkbox"/> SNMA-sponsored program |
| <input type="checkbox"/> teacher/school official) | <input type="checkbox"/> Internet search (SNMA web site) |
| <input type="checkbox"/> Regional program | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> SNMA publication | |

Have you ever participated in a medical education "pipeline" program? If so, which of the following?

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> YSEP (SNMA) | <input type="checkbox"/> HCOP |
| <input type="checkbox"/> HPREP (SNMA) | <input type="checkbox"/> MMEP |
| <input type="checkbox"/> MAPS (SNMA) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> PMED (SNMA) | |

Note: The SNMA National Headquarters occasionally sells portions of the SNMA mailing list to our corporate and organizational partners.

Student National Medical Association * 5113 Georgia Avenue, NW * Washington, DC 20011

(202) 882-2881 * (202) 882-2886-fax * snma@snma.org* www.snma.org

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