ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

# Medical Student Membership Application

AS5012-9

**Please complete all fields and sign application below to apply for your FREE ACP Medical Student Membership. All fields are required unless otherwise noted.**

## Applicant Contact Information

Last_____ First_____ MI____

Dept. Suite Apt. Post Office Box Private Mailbox _____

Street Address_____

City_____ State/Province_____ 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
Month Day Year

Daytime Phone_____

Cell Phone _____

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

**Recovery E-mail Address** _____
(For account authorization and deliverability purposes.)

Other surname used professionally _____
(If applicable; to assist in verifying information)

**For medical students in the United States:**

Current Military Rank (if applicable): _____

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 Month and Year | Anticipated Degree |
|---|---|---|---|---|---|
| | | | | | |

## Demographic Information

**Do you identify as Latinx, Latino, Latina or Hispanic?**
__ Yes __ No Prefer not to answer

**Do you identify as Middle Eastern or North African?**
Yes No Prefer not to answer

**With what racial group(s) do you identify? Please select all that apply.**
Amer Indian, Native Amer, Indigenous or AK Native
Asian, Asian American or Pan Asian
Black, African American or Afro-Caribbean
Native Hawaiian or Pacific Islander
White
Prefer to specify: _____
Prefer not to answer

**What is your gender?**
Woman Man Genderqueer
Non-Binary/Third Gender
Prefer to self-describe: _____
Prefer not to answer

**Do you identify as Transgender?**
Yes No Prefer not to answer

**SIGNATURE OF APPLICANT: I affirm that I have not been the subject of disciplinary action*. I have read the ACP Pledge (www.acponline.org/acppledge) and affirm that I will uphold the ethics of medicine, as exemplified by the standards and traditions of the College.**

***If you have been subject to disciplinary action, please attach a detailed explanation, including current status, of any issue(s).**

**Sign Here** _____
Signature of Applicant **(Required)** Date

**Completed applications should be mailed to:**
American College of Physicians
Member and Product Support
190 N. Independence Mall West
Philadelphia, PA 19106-9855

Reset Form