



*Advancing Family Medicine to Improve Health
Through a Community of Teachers and Scholars*

Fellow Membership Application—\$105

Any fellow in an approved family medicine program, department, or medical school.

Name _____ Degree(s) _____

Title _____

Institution _____

Preferred Mailing Address Office Home

Office Phone _____

Office Fax _____

E-mail _____

Medical School Residency Affiliation

Setting:

University Community Hospital Other _____

Major Professional Role (check one):

Residency Education Medical Student Education Administration

Clinical Practice Research

Other _____

Method of Payment

My check is enclosed (*made payable to STFM in US funds*)

Please charge my credit card as follows: Visa Mastercard AMEX

Card Number _____

Expiration Date _____

Signature _____