



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

## **Student Membership Application—\$25**

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

Name \_\_\_\_\_ Degree(s) \_\_\_\_\_

Institution \_\_\_\_\_

Preferred Mailing Address  Office  Home

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

### **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 \_\_\_\_\_