Florida International University
MEDICAL STUDENT MEMBERSHIP APPLICATION

Dade County Medical Association
Florida Medical Association
American Medical Association

Name in Full: _____
(Please Print)

DOB: _____ Birthplace: _____

Phone: _____ Email: _____

Local Address: _____

City/State/Zip: _____

Permanent Residence Address: _____

City/State/Zip: _____

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single

Spouse's Name: _____

EDUCATION
Pre-College: _____
City/State: _____

College: _____
City/State: _____
Date of Graduation: _____ Degree: _____

Medical School: _____
City/State: _____
Anticipated Date of Graduation: _____

Dade County Medical Association
o 4 year membership= FREE!

Dade County Political Action Committee
o 1 year membership= $5

Florida Medical Association

o Pre-paid membership =$23 (1-4 years)

Florida Medical Political Action Committee (FMA PAC)

o 1 year membership = $10
o 2 year membership = $20

American Medical Association

o 2 year membership = $38
o 3 year membership = $54
o 4 year membership = $68

Dues Total: _____

I, a student enrolled in an American Medical Association approved medical school, hereby make application for membership in the Dade County Medical Association, Florida Medical Association, and American Medical Association and agree to subscribe to the Principles or Ethics of the American Medical Association and Constitution and Bylaws of the Florida Medical Association and the Dade County Medical Association. I hereby certify that I am enrolled in a course of study leading to a degree of Doctor of Medicine in the medical school specified, and that the statements contained in the foregoing application for membership are true and correct. I agree that the veracity of the statements and representations made by me is a prerequisite to medical student membership in the Dade County Medical Association, Florida Medical Association, and American Medical Association and if any are ever determined to be false, that my membership may be terminated without notice or hearing.

Signature of applicant: _____ Date: _____

2 EASY WAYS TO PAY

CREDIT CARD

☐ **Master Card** ☐ **Visa** ☐ **AMEX**

Card#: _____ **Exp Date:** _____

Signature: _____

CHECK

Please make checks payable to:
Florida Medical Association
PO Box 10269
Tallahassee, FL 32302
800.762.0233 Fax: 850.224.6627

In an effort to keep dues low, the FMA and DCMA have entered into several endorsement agreements with various vendors. As part of the endorsement agreement, the FMA and DCMA will include advertisements from the vendors on newsletters and other material faxed and emailed to our members. By virtue of your membership in the DCMA and FMA, you consent to the receipt of these unsolicited advertisements, unless you specifically opt out by notifying the DCMA and FMA in writing of your desire not to receive any materials via fax or email. Tax Deduction Information for your records, please note that the Revenue Reconciliation Act of 1993 states that association dues used for lobbying activities are not deductible as a business expense. As a result, 10% of your DCMA dues, 25% of your FMA dues, and 50% of your AMA dues for 2009 cannot be deducted as a business expense for income tax purposes. While Association dues are not tax deductible as charitable contributions for federal income tax purposes, they may be tax deductible under the provisions of the Internal Revenue Code.