





# AKMG Membership Application

Mail this form along with your payment to:  
 AKMG Membership Dues  
 P. O. Box 74703, Cleveland, OH 44194-4703

<b>Association of Kerala Medical Graduates</b>		
AKMG Membership Number (See mailing label, if available):		
Last Name:	First Name:	M.I.:
Home Address:		
City:	State:	Zip:
Home Phone:	Office Phone:	
Fax:	E-mail:	
Specialty:		
Medical College:		Year Entered:
Spouse Name:		Is spouse MD?
*Please fill out a separate form, if spouse is a physician and applying for Joint Membership.		
Comments:		
<b>Membership Fees</b>		
<input type="checkbox"/>	Life Membership (\$350 until 07/04/09) .....	US\$ 500.00
<input type="checkbox"/>	Joint Life Membership (\$500 until 07/04/09)* .....	US\$ 750.00
<input type="checkbox"/>	Annual Membership .....	US\$ 50.00
<input type="checkbox"/>	Joint Annual Membership* .....	US\$ 75.00
<input type="checkbox"/>	Resident/Fellow Membership .....	US\$ 10.00
<input type="checkbox"/>	Medical Student Membership (Year of Graduation: _____) .....	No Charge
<input type="checkbox"/>	Donation to AKMG_HS (Optional) .....	US\$ _____
*Joint Membership is available for physician couples.		
	Please make check payable to 'AKMG and mail it to: AKMG Membership Dues P. O. Box 74703, Cleveland, OH 44194-4703	
	Send membership inquiries to: membership@akmg.org	