

AKMG Membership Application

Special Discount on Life Membership until 06/30/06

AKMG Membership Number (See Mailing Label): _____

Last Name: _____ First Name: _____ M. I. : _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Home Fax: _____

Office Phone: _____ Office Fax: _____

E-mail: _____

Specialty: _____

Medical College: _____ Year Entered: _____

Spouse Name: _____ Profession: _____

Academic Appointment (Please circle type): Full Time / Part Time / Clinical _____

Current Rank: _____ School: _____

Hospital Name: _____

Appointment Title: _____

Comments: _____

***Special Discount
on Life Membership
until 06/30/06***
Life Membership is available
at a discounted rate of \$350 for
individual physician and \$500
for a physician couple.

- Life Membership **(\$350 before 06/30/06)** \$500
- Joint Life Membership (Couple) **(\$500 before 06/30/06)** \$750
- Annual Membership \$50
- Joint Annual Membership (Couple) \$75
- Resident/Fellow Membership \$10
- Student Membership No Charge

Please make check payable to "AKMG" and mail it to:

AKMG Membership Dues
P. O. Box 74703
Cleveland, OH 44194-4703