USF MEDICAL STUDENT MEMBERSHIP APPLICATION FOR THE HILLSBOROUGH COUNTY MEDICAL ASSOCIATION, INC. (HCMA)

Fax to: HCMA, 813/253-3737, or mail: HCMA, 606 S. Boulevard, Tampa, FL 33606

Print Full Name: _____ MS, I, II, III, IV

Application Date: _____

Address: _____

Apt #_____

City, Zip: _____

Phone_____

E-mail:_____ Spouse's Name: _____

Sex: _____ Birth date: _____ Birth place: _____

Education:

Med. School: **USF College of Medicine, Tampa, FL - Year of Graduation:** _____

By my signature, I agree to accept and be bound by the Articles of Incorporation and Bylaws of the HCMA, and the Principles of Medical Ethics of the AMA, together with all future amendments of such Articles of Incorporation, Bylaws, or Principles of Medical Ethics, which may be duly adopted by the respective organizations.

I hereby certify that the foregoing is true and correct to the best of my knowledge. I understand and agree that if I knowingly make a false representation in this application or a representation that in the exercise of reasonable care I should have known to be false, the HCMA has the authority to reject this application.

Printed Name: _____ Date: _____

Medical Student Member Dues

N/A

***As of November 2009, the HCMA Board of Trustees has waived dues for all medical students.**

Signature:

_____

(You can reach the HCMA Headquarters at 813/253-0471)