



National Arab American Medical Association

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الجمعية الطبية العربية الأمريكية

APPLICATION FOR CORRESPONDING MEMBERSHIP

إستمارة إنتساب - عضو مراسل

Name _____ Title _____

Mailing address _____

City _____ Country _____

Business telephone (_____) _____ Fax (_____) _____

E-mail: _____

Date of birth: _____ Country of birth _____

Medical/dental/other school attended _____

Year graduated _____ Degree(s) _____

Medical license, Country & date _____

Specialty: _____ Subspecialty: _____

If student or resident, state year and program _____

Type of practice: _____

University affiliation (if applicable) _____

Position _____

Applicant's signature: _____ Date: _____

*Membership Dues for Corresponding members is complementary. Members are notified about NAAMA's activities, news and updates electronically. If you wish to receive mailings of NAAMA's publications (Al Hakeem, Newsletter, Brochures) at a similar frequency as our Active members. A **\$50 US dollars** membership fee is required.*

Method of Payment (if applicable)

Money Order/ Certified Check (all checks should be in US currency and made payable to NAAMA)

Credit Card: _____ VISA _____ MasterCard _____ American Express

Card Number _____ Expiration Date _____

Name on Card _____

Please complete application and mail or fax it to the address above

أهلاً وسهلاً