The Association of Minnesota Chinese Physicians
Membership Application

Name: _____ Chinese name:_____

Date of birth:_____

mailing address

Phone:

(Cell) _____ (H) _____ (W) _____

Email _____

Medical school or graduate school: _____

Degree and year of graduation: _____

Specialty or occupation: _____

Practice status:

[ ] practicing [ ] in training [ ] retired

Clinic/hospital:

_____

_____

References: List a reference preferably a current AMCP member. If the reference is not an AMCP member, please also provide his/her address.

_____

Membership Dues (please check one):

Regular member:

[ ] Staff physicians $50

[ ] TCMD physicians $25,

[ ] Physicians in training or associate members $25

Lifetime member Dues:

[ ] Staff physicians $500

[ ] TCMD physicians $250