It is time to activate your membership for **Fiscal Year 2017**! Please complete and return the form below or to complete online, visit **AlabamaMedicalAlumni.org**.

<Full Name> **Oct 2016-Sept 2017**

Medical Alumni Association Dues Form

Membership Levels:

Student Membership	$15
Current Residents and Fellows	$25
Active Alumni Membership	$100
Silver	$250
Gold	$500
Platinum	$1,000

My 2017 Dues – 100% tax deductible .....$_____

Each annual membership is eligible to take part in the *University Benefits Package* which includes business discounts and group savings. To take advantage of these benefits, please check the box below. For more details and to see the benefits available to you, please see our website.

☐ **Send Benefits Package**

If left unchecked, it is assumed you are not taking advantage of the benefits offered.

Contributions

Dues must be paid per fiscal year to be considered an active member.

Contributions added to current dues determine your membership level.

Medical Alumni Association/Dean of Medicine Scholarship Fund ....._____

Medical Alumni Association Endowed Medical Scholarship Fund....._____

Jimmy W. Beard Memorial Scholarship Fund ....._____

Medical Student Assistance Fund....._____

Medical Alumni Association Endowment (Perpetuity) Fund ....._____

TOTAL.....$_____

For payments by credit card: □ MasterCard □ VISA □ Discover □ AMEX

Name as it Appears on Card _____

Card # _____ Expiration Date_____ CVV_____

Billing Address _____ City_____ State ____ Zip _____

Billing Phone _____ Email _____

Your ID< # > is your member number for the On-Line Directory. Your last name is the password.

Mailing Address: VH Box 111, 1720 2nd Avenue South, Birmingham, AL 35294-0019

www.AlabamaMedicalAlumni.org

BIOGRAPHICAL INFORMATION

Please help the Medical Alumni Office update your records by completing this form.

New information may be used in the Medical Alumni Newsletter and in Class Notes.

↓ Please check one for preferred mailing address:

____ Home address:_____ Tel. No. ( ) _____

_____ Cell No. ( ) _____

____ Office address:_____ Tel. No. ( ) _____

_____ Fax No. ( ) _____

___ E-mail address:_____

Medical School_____Year _____

Internship at_____Years (From)_____(To)_____

Specialty in_____

Residency at_____Years (From)_____(To)_____

Specialty in_____

Fellow at_____Years (From)_____(To)_____

Specialty in_____

Undergraduate School_____Year _____Degree_____

Armed Services_____Years (From)_____(To)_____

Type of Practice (i.e.: Full Time Hospital, Private, Faculty, Administrative, Military, Research, Resident, etc.)

_____

Practice Specialty (Primary)_____ Secondary Specialty_____

Date of Birth_____ Married/Single_____ Spouse's Name_____

Children (if new birth, please list date)_____

_____

CLASS NOTES:

Recent Honors, Awards, Appointments or **Publications** within the last year. (Please write legibly)

_____

_____

FAMILY LEGACIES:

We would like to record SOM legacies in your family!

Name: _____ Birth Date _____

SOM Graduating Class _____ Relationship to You _____

☐ **If you have included the Medical Alumni Association in your estate plans, please let us know.**

☐ **I would like information on including the Medical Alumni Association in my estate plans.**