



It is time to activate your membership for **Fiscal Year 2018!** Please complete and return the form below or to complete online, visit **AlabamaMedicalAlumni.org**.

Oct 2017 – Sept 2018

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 2018 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.

Medical Alumni Association/Dean of Medicine Scholarship Fund_____

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

Jimmy W. Beard Memorial Scholarship Fund_____

Contributions added to current dues determine your membership level.

Medical Student Assistance Fund....._____

Medical Alumni Association Endowment (Perpetuity) Fund_____

TOTAL DONATION (Dues plus Contributions).....\$_____

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

Phone: 205-934-4463 www.AlabamaMedicalAlumni.org

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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.