



## Join MAG's Medical Student Section

Please complete the information below to apply for membership to the Medical Association of Georgia.

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Medical School \_\_\_\_\_ Expected Year of Graduation \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Payment Information - \$5 Student Dues** (One time payment for the duration of your education)

Payment Method:     Check (Made payable to the Medical Association of Georgia)  
                           Credit Card (check one)     Visa     MC     AMEX

Name (as it appears on card): \_\_\_\_\_

Number: \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

***Please mail or fax membership application to:***

Medical Association of Georgia

PO Box 101993

Atlanta, GA 30392-1993

(Fax) 678-303-9264

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