MEMBERSHIP APPLICATION FORM

First Name:	Middle Name:	Last Name:
Address:		
City:	State:	Zip Code:
Phone:	Email:	Year of Graduation:

☐ Lifetime Membership Dues	US$ 500.00
☐ Annual Membership Dues (Jan 1st -Dec 31st)	US$ 50.00
☐ Scholarship Donation	US$_____
☐ Donation for Endowment Fund	US$_____

☐ **I CERTIFY THAT I WILL ABIDE BY THE RULES & REGULATIONS OF FJMCAA**

_____

Print Name

_____ _____

Signature Date

Make checks payable to FJMCAA and mail with form to:

Shagufta Jabeen, MD
531 Turtle Creek Dr
Brentwood, TN 37027

Nighat Mehdi, MD
2816 Perth Drive
Edmond, OK 73013

FJMCAA requires a copy of medical license in USA from all new members to become a voting member.