Physician-in-Training Letter

FOR VERIFICATION PURPOSES ONLY

Date:_____

Name:_____

Job Title: _____

Organization:_____

Address 1:_____

Address 2:_____

City/State/Zip:_____

E-Mail:_____ Phone: _____

This letter verifies that I,_____, am a physician-in-training and therefore eligible to receive the reduced membership rate. I understand that my membership status is contingent upon my participation in one of the training programs listed below.

I am currently a: Resident

I am in my: First Year

Years Participating in Program: _____ to _____
mm/yyyy *mm/yyyy*

Program Director's Name: _____

Institution: _____

I hereby acknowledge that all of the above information is accurate.

_____ _____

Applicant Signature ***Program Director Signature***

In order to verify membership status and receive the discounted rate, complete all required information and return with dues payment. If you paid online for membership already, you do not need to send payment with this form.

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