Association For Academic Minority Physicians (AAMP) Proposed Individual Membership information

This form should be included with the proposer's letter of nomination.

Nominee's Information:

Title: _____Name:_____Suffix:_____

Degrees: _____

Faculty Appointment: _____

Medical School Affiliation: _____

Department: _____

Phone Number: _____ Fax Number; _____

Email Address: _____

Office Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Proposer's Information

Full Name and Title: Title: _____ Name: _____Suffix:_____

Degrees: _____

Medical School Affiliation: _____

Department: _____

Phone Number: _____Fax Number:_____

Email Address: _____

Signature: _____

Date: _____

ELECTRONIC SUBMISSION IS PREFERRED to dwilson@aampinc.org. Please use this linked form to enter the details about the proposed member and save it as a PDF to submit with the rest of the scanned required documentation.