American College of Physicians
Leading Internal Medicine, Improving Lives

Medical Student Membership Application

AS4002-7

Please complete all fields and sign application below to apply for your FREE ACP Medical Student Membership. All fields are required unless otherwise noted.

Applicant Contact Information

Last_____ First_____ MI____

Dept. Suite Apt. Post Office Box Private Mailbox _____

Street Address_____

City_____ State_____ ZIP +4_____

Country_____ Mailing Address: Home Office

Please check here if you wish to be excluded from non–ACP-related mailings.

Applicant's ACP # (if known) ☐☐☐☐☐☐☐☐☐

Code:_____

Date of Birth Month Day Year
Month Day Year

Daytime Phone_____

Cell Phone _____

Preferred E-mail Address_____
(Required for immediate access to online member benefits, including journals)

Recovery E-mail Address _____
(For account authorization and deliverability purposes.)

Other surname used professionally _____
(If applicable; to assist in verifying information)

For medical students in the United States:

Current Military Rank (if applicable): _____

I wish to be part of the following U.S. Armed Forces ACP Chapter:
U.S. Army U.S. Air Force U.S. Navy

Medical School

Only students enrolled in a medical school included in the World Directory of Medical Schools (www.wdoms.org) are eligible.

Name of Medical School	City	State/Province	Country	Anticipated Graduation Month and Year	Anticipated Degree

Demographic Information

Do you identify as Latinx, Latino, Latina or Hispanic?
Yes No Prefer not to answer

Do you identify as Middle Eastern or North African?
Yes No Prefer not to answer

With what racial group(s) do you identify? Please select all that apply.
Amer Indian, Native Amer, Indigenous or AK Native
Asian, Asian American or Pan Asian
Black, African American or Afro-Caribbean
Native Hawaiian or Pacific Islander
White
Prefer to specify: _____
Prefer not to answer

What is your gender?
Woman Man Genderqueer
Non-Binary/Third Gender
Prefer to self-describe: _____
Prefer not to answer

Do you identify as Transgender?
Yes No Prefer not to answer

SIGNATURE OF APPLICANT: I affirm that I have not been the subject of disciplinary action*. I have read the ACP Pledge (www.acponline.org/acppledge) and affirm that I will uphold the ethics of medicine, as exemplified by the standards and traditions of the College.

***If you have been subject to disciplinary action, please attach a detailed explanation, including current status, of any issue(s).**

Sign Here _____
Signature of Applicant **(Required)** Date

Completed applications should be mailed to:
American College of Physicians
Member Credentialing
190 N. Independence Mall West
Philadelphia, PA 19106-9855

Reset Form