AIRLINES MEDICAL DIRECTORS ASSOCIATION

APPLICATION FOR MEMBERSHIP
(PLEASE TYPE OR PRINT)

REQUIREMENTS:

A. An applicant must be a licensed health care professional who is an *active member of the Aerospace Medical Association,* verified by inclusion in the AsMA online directory or a copy of the applicant's AsMA membership card.

B. The application form must be signed by *two active members of the Airlines Medical Directors Association,* or by *one active member and one Emeritus member.*

C. The applicant must provide two letters of reference, one from the AMDA primary sponsor, and the second from an airline medicine sponsor, verifying his/her interest/affiliation with airline medicine.

D. Include a check for $90 (U.S. currency), made payable to "Airlines Medical Directors Association". If check payment in U.S. funds is not convenient, we can accept payment by MasterCard or Visa, in which case please complete the payment authorization on Page Three of this form.

Applications will be reviewed at the Annual Meeting of the AMDA in May of each year, but they must be post-marked by May 1 in order to be reviewed at that year's meeting. The application and supporting documents must be filed with the Secretary of the AMDA. The application fee of $90 includes the $25 initiation fee and $65 for the first year's assessment and dues. (Subsequent dues are $50 annually.) In the event the application is not accepted, the entire $90 application fee will be returned to the applicant.

The Executive Council will decide whether the applicant is eligible for *Active* or *Associate* membership.

Applicant Information

_____ _____ _____
First Name(s) Middle Name or Initial Last (Family) Name(s)

_____ _____
Professional title (M.D., PhD, etc) Birthdate (Month, date, year)

Address for Directory **Preferred Mailing Address (if different)**

_____ _____
_____ _____
_____ _____
City/State/Country _____ City/State/Country _____

Business Phone _____ Home Phone _____ Mobile Phone_____
(Optional) (Optional) (Optional)
Fax Number _____
Primary Email _____
Secondary Email _____
(Optional)

Professional Information

Degrees (M.D., etc.) _____
Licensed to Practice in Major Field of Professional Activity _____
Specialty Board Certification(s) _____
Year of Graduation _____
(State, Province, or Country) _____

Professional Affiliations

_____
_____
_____
_____
_____

State briefly your interest in airline medicine. If affiliated with an airline, give your title/position and the company name and mailing address if different from yours. Also, describe the nature of your responsibilities and duties within the company, whether you are an employee or a consultant, the number of hours per week you devote to this, etc. A photocopy of your Employee I.D. is helpful, if you have one.

_____
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_____
_____
_____
_____
_____

Recognizing that further inquiry into my application is desirable, I authorize the Membership Committee to make further investigation and to submit its findings to the Association.

_____ _____
(SIGNATURE OF APPLICANT) (DATE)

Names and Signatures of two AMDA Active or Emeritus members:

Primary Sponsor: _____ _____ _____
(Signature) (Name Printed) (Date)

Second Sponsor: _____ _____
(Signature) (Name Printed) (Date)

Please Include Sponsor letters in this application

Submit completed application to:

Petra A Illig, M.D., Secretary
Airlines Medical Directors Association
5011 Spenard Rd. #205
Anchorage, AK 99517
OR via fax to: 907-245-2212
OR via email to: petra.illig@gmail.com

Please include a check made out to AMDA, or if you wish, you may pay the application fee by credit card by filling out the following:

I authorize the AMDA Treasurer to charge the $90 application fee to the following account:

Circle type of card: VISA Master Card
Card Number: _____
Exact name on the credit card: _____
Expiration Date: _____

_____ _____
(Signature of Applicant) (Date)

END OF APPLICATION