Afghan Medical Professionals Association of America (AMPAA)

Membership Application Form

I. APPLICANT INFORMATION

Name: ____
(First Name, Middle Name, Last Name, Suffix, Designations)

Address: ____

Phone: ____

Email: ____

Occupation/Title: ____

Employer: ____

Are you interested in volunteering for AMPAA? ☐ Yes ☐ No

If yes, select your area(s) of interest and expertise:

- ☐ Serving as AMPAA Health Ambassador to promote community health
- ☐ Mentoring students and young professionals
- ☐ Serving in AMPAA committees
- ☐ Providing administrative/operational support to AMPAA
- ☐ Event organization and management
- ☐ Donating to AMPAA/becoming a financial sponsor

II. MEMBERSHIP AND PAYMENT DETAILS

A. Choose type of membership and associated annual dues:

- ☐ Active healthcare providers: $175
- ☐ Residents: $75
- ☐ Non-practicing/retired members: $50
- ☐ Students: $25

B. Would you like to make an additional donation/financial contribution to AMPAA? ____

C. Payment:

By submitting this form you confirm that you agree with the AMPAA mission and values as a humanitarian, nonprofit, and nonpolitical organization that provides assistance and support to communities and individuals without any discrimination and regardless of culture, language or religion. Thank you for choosing AMPAA for your professional, volunteer, and charitable goals.