KENT YOUNG PHYSICIANS ASSOCIATION

APPLICATION FOR MEMBERSHIP

Contact Information

Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

Credentials

Tell us about your work background:

Guest Lecture

Are you interested in giving a guest lecture? If yes, provide a lecture topic:

Volunteer

Are you interested or available to volunteer with KYPA? Describe your availability and skills.

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a member of the Kent Young Physicians Association, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Name (printed)	
Signature	
Date	

Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in becoming a member of the Kent Young Physicians Association.

Please fill this form out and e-mail it to membership@kypa.biz or bring it to our next monthly meeting along with a check or credit card to pay your $100 yearly membership fee.