



Iranian American Medical Association (IAMA)

P.O. Box 8218
Haledon, NJ 07538-0218
Phone: (973) 595-8888

E-mail: iama@iama.org
Website: www.iama.org
Fax: (973) 790-7755

Membership Form

(January 1, 2009 -----December 31, 2009)

Date: _____ Specialty: _____

First Name: _____ Last Name: _____

Address: _____

Phone #: _____ Email: _____

Practice Website: _____

Would you like to receive communications from IAMA or IAMA-Javaan via E-mail? Y () N ()

Annual Membership Fee:

(Please choose and circle one of the categories below that best describes your position)

IAMA:

Practicing MD, DMD, DDS, OD, DVM, Pharm.D, Ph.D, DPM, DCM, DO: **\$ 100**
PA, RN, Med.Tech: **\$ 50**

Retirees: **\$ 50**

IAMA-Javaan members: **FREE**

IAMA-Javaan*:

Students, Post.Docs: **\$ 10**

Residents, Fellows: **\$ 25**

*) IAMA-Javaan members are honored free membership in **IAMA**, and the fees of \$10 and \$ 25 are only for the membership in and support of **IAMA-Javaan**.

Please complete the form and mail it to the IAMA address or your local chapter along with your membership fee by check or money order payable to IAMA or IAMA-Javaan.

In addition, on-line registration and payment option (via IAMA or IAMA-Javaan's secure PayPal accounts) are also available on IAMA website. For more information about this please visit IAMA website at www.iama.org

Please continue to the next page for your Demographic Information. Thank you!



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Demographic Information

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First Name: _____ Last Name: _____

Date of Birth: _____ Place of Birth: _____

Home Address: _____

Home Phone: _____ E-mail address: _____

Graduate School: _____

Year of Graduation: _____ Years in Practice: _____

Post Graduate Training: _____

Medical school Affiliation: _____

Teaching Appointments: _____

Recognition Award Nominee: _____

I would like to assist IAMA by acting as a member of IAMA Committees/Chapters () -

I would like to participate in the trip(s) to Iran: Yes () No ()

I would like to offer my service in Moassesehe Pezeshiki IAMA in Bam () **Referral:** Please inform your colleagues in the Iranian-American Medical fields about IAMA, and if you would like us to contact them to become a member, please indicate their contact information here:



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Donation Form

(January 1, 2009 -----December 31, 2009)

Date: _____ Specialty: _____

First Name: _____ Last Name: _____

Office Address: _____

Office Phone #: _____ Office Fax #: _____

E-mail: _____

Would you like to receive communications from IAMA or IAMA-Javaan via E-mail? Yes () No ()

Please check one of the following statements that best describes your donation.

- () I am a current member of IAMA / IAMA-Javaan, and would like to make the following (tax deductible) donation. My donation is: \$ _____
- () I am not a current member and I am not interested in becoming a member, however, I would like to make the following (tax deductible) donation of: \$ _____
- () I am not a current member of IAMA / IAMA-Javaan, but I would like to receive more information about the membership and activities of IAMA / IAMA-Javaan, and I would like to make the following (tax deductible) donation. My donation is: \$ _____

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