Vietnamese American Medical Professionals

Hội Y Nha Dược Florida

www.vampgroup.org

2025 Annual Membership Application

Note: Membership is based on Calendar year from Jan through Dec

Last Name _____ **Middle**_____ **First**_____

Professional Designation (please circle)
MD DO DMD DDS PharmD OD PA-C ARNP DC STUDENT Other: _____

Specialty _____

Mailing Address_____

Phone _____ **Email:** _____

If Healthcare Professional Student: Current Professional School: _____

Student Email: _____ **Expected Graduation Date** _____

Membership Dues	**Tax Deductible Donations** (Community Service, Magazines, CE courses, YND events)
[ ] FREE - Student [ ] $85 - One Year dues [ ] $210 - Three Year dues	[ ] $20 [ ] $50 [ ] $100 [ ] Other $ _____
TOTAL	

I am paying by [ ] Check [ ] Credit Card [ ] Zelle to vampgroupfl@gmail.com **[ ] PayPal**

If paying by Zelle, please add **vampgroupfl@gmail.com** to your Contacts first.
If paying by PayPal, please go to **www.vampgroup.org/payment.**

Credit Card Payment [ ] Visa [ ] MasterCard
Name on Card:_____
Card Number: _____ CVC (3 digit # on back of card): _____
Expiration Date: _____/_____ Amount: $ _____
Zip Code: _____
Signature:_____ Date: _____

Please make check payable to **Vietnamese American Medical Professionals** and mail to the following address:

Son Ho, M.D.
1517 Cloverlawn Avenue
Orlando, FL 32806

Thank you for your support!