



Vietnamese American Medical Professionals

Hội Y Nha Dược Florida

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2026 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	☐ \$20
☐ \$85 - One Year dues	☐ \$50
☐ \$210 - Three Year dues	☐ \$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: _____

Expiration Date: ____/____

Signature: _____

CVC (3 digit # on back of card): _____

Amount: \$ _____

Zip Code: _____

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!