Vietnamese American Medical Professionals

Hội Y Nha Dược Florida

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2027 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 to VAMP Foundation** (Community Service, Magazines, CE courses, YND events)
[ ] FREE - Student [ ] $100 - One-Year dues [ ] $275 - Three-Year dues [ ] $1000 - Lifetime 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:

Ly Nguyen, M.D.
12837 Broleman Road
Orlando, FL 32832

Thank you for your support!