**AFSM Individual or Associate Membership**

**Application Form**

Please send the completed form with **payment slip** to [afsm.membership@gmail.com](mailto:afsm.membership@gmail.com). Membership is subject to the approval of the AFSM Executive Committee.

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| **Personal Details\*** | | | | |
| Title | Prof.　　  Dr.　　  Mr. 　　 Ms. | | | |
| First name |  | Last name |  | |
| Contact Number |  | Email |  | |
| Postal address |  | | | |
| Country / Region |  | Nationality |  | |
| **Professional Qualification\*** | | | | |
| Position |  | | | *(Job title / Job Position)* |
| Affiliation |  | | | *(Hospital / Practice / Institute)* |
| Specialty / Subspecialty |  | | | *(e.g. Orthopaedics: Knee)* |
| Area of Interest |  | | | |

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| **Membership Type\*** (Please click the appropriate checkbox) | | | |
| **Individual Membership** |  | 1 Year | USD$30 |
|  | 4 Years | USD$100 |
|  | (Life) | **USD$300** |
| **Associate Membership** |  | 1 Year | USD$30 |
|  | 4 Years | USD$100 |

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| **Please attach payment slip together with this form.** (Please click the appropriate checkbox)  Your membership will be confirmed only after successful payment of membership.  Payment method: [www.afsmsportsmed.org/payment](https://www.afsmsportsmed.org/payment) | |
|  | I have attached the payment slip by **PayPal**. |
|  | I have attached the payment slip by **Bank Transfer**. |

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| **Special Remarks (Optional)** |  |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**