**AFSM Individual or Associate Membership**

**Application Form**

Please send the completed form with **payment slip** to 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**