



2019 Application for AzVMA Student Membership

Please complete the following application and mail it with your payment, to AzVMA, 100 W Coolidge St, Phoenix, AZ 85013.

Applicant Information

Name: _____

Local Address: _____
City State Zip

Phone: _____ Cell: _____ Date of Birth: ____/____/____ Male Female

Official School Email: _____ (for verification purposes)

Alternate Email: _____

School Information

School: _____ Studying:

Address: _____ Small Animal Large Animal
City State Zip Mix Exotics

Degree: _____ Equine Other

Anticipated Graduation Year: _____ Home State: _____

Areas of Interest

Please select up to **FIVE (5)** Areas of Interest to list in your Annual Membership Directory profile.

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Hematology	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Soft Tissue Surgery
<input type="checkbox"/> Allergy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Immunology	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Alternative Therapy	<input type="checkbox"/> Emergency	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pathology	<input type="checkbox"/> Stem Cell Therapy
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Intensive Care	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Surgery
<input type="checkbox"/> Avian	<input type="checkbox"/> Endoscopy	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Preventative	<input type="checkbox"/> Toxicology
<input type="checkbox"/> Behavior	<input type="checkbox"/> Epidemiology	<input type="checkbox"/> Lameness	<input type="checkbox"/> PT/Rehab	<input type="checkbox"/> TPLO Certified
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Equine	<input type="checkbox"/> Laser Surgery & Therapy	<input type="checkbox"/> Public Health	<input type="checkbox"/> Urology
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Exotics	<input type="checkbox"/> Neurology	<input type="checkbox"/> Radiology	<input type="checkbox"/> Vestibular Disease
<input type="checkbox"/> Coccidioidomycosis	<input type="checkbox"/> Genetics	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Reproduction	<input type="checkbox"/> Wildlife
<input type="checkbox"/> Diagnostic Screening	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Oncology	<input type="checkbox"/> Reptiles	
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Hearing	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Shelter Medicine	

Payment Options

Student Membership	\$12
--------------------	------

- I give my permission to include my contact information in the AzVMA membership directory.
- I give my permission to share my contact information with other veterinary students.
- I would like to be involved with the Young Leaders Advisory Committee (YLAC).

Signature constitutes acceptance of and intention to be bound by the Articles of Incorporation, Constitution, and Bylaws of this Association and the Principles of Veterinary Medical Ethics of the American Veterinary Medical Association together with all amendments, present and future, of such Articles, Constitution, Bylaws, or Principles of Veterinary Medical Ethics which may be duly adopted pursuant to the provisions thereof, and to continuously strive for the advancement of the profession. I am aware that my application must be accompanied by a copy of my current state veterinary license or acceptable alternative and approved by the Board of Directors. If there are changes to my contact information, I understand it is my responsibility to update my member profile online or notify the AzVMA office in writing immediately. Questions should be sent to membership@azvma.org or call the AzVMA office at 602-242-7936.

Credit Card Type: American Express Visa MasterCard Discover

Credit Card Number: _____ Name on Credit Card: _____

Security Code: _____ Expiration Date: _____ Zip Code: _____

Signature: _____ Date: _____