Application for Medical Student Membership

PERSONAL INFORMATION *(Please print or type)*

Name: _____ Date: _____
(*Full Legal Name*)

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____ Suite No: _____

City: _____ State: _____ ZIP: _____

*Personal E-mail: _____ ☐ Do Not Display

*Work E-mail: _____ ☐ Do Not Display

*Phone: _____ ☐ Do Not Display *Cell: _____ ☐ Do Not Display

* *Unless indicated in the "Do Not Display" box, this information will be included in your online directory listing that can be viewed by other TSA members.*

Preferred E-mail: ☐ Personal ☐ Work Preferred Phone #: ☐ Phone ☐ Cell

MEDICAL SCHOOL INFORMATION

Medical School: _____

Medical School Address: _____ Suite No: _____

City: _____ State: _____ ZIP: _____

Date of Enrollment: _____ Anticipated Date of Graduation: _____

Active TSA Member: _____

Active TSA Member Signature: _____

Applicant's Signature: _____ **Date:** _____

Email completed form to:
Texas Society of Anesthesiologists
info@tsa.org

Or fax to:
Attn: Membership
(512) 370-1655

Applications are processed on the 15th of each month.