



The College of Physicians of Philadelphia

BIRTHPLACE OF AMERICAN MEDICINE®

Section on Public Health and Preventive Medicine

Membership Application/Renewal Form

Send completed forms to publichealth@collegeofphysicians.org.

Name: _____

Title: _____ Organization: _____

Mailing Address: _____

_____ Zip Code: _____

Primary Email: _____ Phone Number: (____) ____ - _____

Alternate Email: _____

Students: Please put your personal email here.

Fellow New Member Renewal Student

Areas of Interest: _____

Annual Membership Dues (\$50):

Membership is free for students. Please indicate above if you are applying for a student membership.

To pay dues online, visit <https://www.collegeofphysicians.org/about-us/support/section-memberships>.

Please charge my VISA MasterCard

Card # _____

Expiration Date _____

Signature _____

If cardholder's name is different from member, please indicate here:

OR

Enclosed is my check for \$_____. Please make check payable to "*The College of Physicians of Philadelphia*"

Mail to: Section on Public Health and Preventive Medicine

The College of Physicians of Philadelphia
19 South 22nd Street
Philadelphia, PA 19103-3097