



BANGLADESH MEDICAL ASSOCIATION OF NORTH AMERICA

MEMBERSHIP FORM

ELIGIBILITY:

- Physicians or dentists who are graduates of Medical Colleges from Bangladesh or are Physicians of Bangladeshi descent who are licensed to practice Medicine or Dentistry in USA or Canada.
- Physicians or Dentists who are graduates of Medical Colleges from Bangladesh or are Physicians of Bangladeshi descent who are engaged in residency/fellowship, full time research or academic Medicine for more than 3 years.

FEES: Life Membership: \$ 500.00 Active Members: \$ 75.00/ year Associate Members: \$ 50.00

Last Name: _____ First Name: _____

Full Middle Name: _____

Home Address: _____

City _____ State _____ Zip _____

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Current Position: _____

(Attending, Resident, Fellow, Faculty, Research, Academic or other position)

Tel: Home: _____ Cell: _____ Office: _____

E-mail: _____

Medical School: _____ Year of Graduation: _____

Preferred Mailing Address: Home Address Office Address

STATEMENT: To the best of my knowledge, the information is the correct status of my professional activity.
 I agree to disclose above information's for BMANA membership registry & publication.

Signature: _____ Date: _____

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