SOUTH DAKOTA STATE MEDICAL ASSOCIATION
Values. Ethics. Advocacy.

STUDENT MEMBERSHIP APPLICATION

Thank you for your interest in joining the South Dakota State Medical Association. Please complete the entire application for consideration as a member in this Association. This application must be submitted to SDSMA by the Sanford School of Medicine, or be accompanied by proof of enrollment in a school of medicine.

APPLICANT INFORMATION

First Name:____________________ Middle Name: __________________ Last Name:____________________

Date of Birth: ______________________________ Gender: Female ☐ Male ☐

School Address:______________________________ Permanent Address:__________________________

City: ____________________________________ City:_____________________________________

State:_____________ Zip Code: ________________ State:___________________ Zip Code:__________

Cell Phone:_________________________________ Email:____________________________________

Spouse:____________________________________

Preferred Mailing Address: School ☐ Permanent ☐

EDUCATION

Post-Secondary Education

College/University Name:____________________________ Location:____________________________

Degree Received: _________________________________ Date of Completion:____________________

Medical Education

Medical School Name:_____________________________ Location:____________________________

Expected Graduation Date:__________________________

MEMBERSHIP

Medical Students are eligible to be Associate Members of the South Dakota State Medical Association. SDSMA membership dues along with American Medical Association (AMA) membership dues for Medical Students are paid by sponsoring SDSMA physician members for all four years of medical school. Students will be notified of the name and contact information of their sponsoring physician and will be asked to write a personal thank you. As a member of SDSMA, medical students receive mailings from the SDSMA Office, are represented on the SDSMA Council of Physicians, and are eligible and encouraged to participate in all member benefits.

Please sign and date second page to complete your application.

AFFIRMATION AND SIGNATURE

I certify that I am a student in good standing at the medical school listed in this application. The applicant hereby verifies and confirms that the information provided above (and, as applicable, attached hereto) is true, accurate and complete, and that the applicant qualifies for the class of membership for which the applicant has applied. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial of my application for membership or revocation of my membership.

I authorize the Sanford School of Medicine of the University of South Dakota to provide my current mailing address and enrollment status to the South Dakota State Medical Association (SDSMA) for as long as I am enrolled in the school.

I hereby make application for membership in your Association and, if accepted as a member, I agree to support its Bylaws, and to conduct myself professionally according to the principles of medical ethics of the South Dakota State Medical Association.

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Applicant Signature

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Date of Signature

RETURN INFORMATION

Questions regarding this application should be directed to:
South Dakota State Medical Association
605.336.1965 * Fax: 605.274.3274 * membership@sdsma.org * www.sdsma.org

Return completed application to:
Executive Assistant to the Dean at the USD Sanford School of Medicine