



Join the AMA Alliance

The Alliance is the conduit that not only plugs members into knowledge, resources and opportunity, but also helps them conveniently and personally advocate on behalf of their future, the future of medicine and the interest of the family of medicine in health care reform. Join us and add your voice to ours on behalf of the future we will share.

AMA Alliance membership dues are \$50 per year for members of a physician couple; \$10 per year for resident physicians, resident physician spouses and partners, medical students, and medical student spouses and partners.

All physicians (must be an AMA member) and physicians' spouses and partners are welcome in the AMA Alliance. To join, complete the membership application below and begin to enjoy the benefits of belonging to the only national organization representing the family of medicine today.

Residents of Illinois, Oklahoma and Texas must go through the state Alliance to join. Please call the AMA Alliance at (312) 464-4470 for more information about joining if you live in Illinois, Oklahoma or Texas.

* Denotes a required field.

Member Classification

Select the type of Alliance membership*

- Regular \$50
- Medical Student \$10
- Medical Student Spouse/Partner \$10
- Resident physician \$10
- Resident Physician Spouse/Partner \$10

Contact Information

Name * _____

Address* _____

City* _____ State* _____ ZIP Code* _____

Phone* _____

E-mail* _____

Your e-mail address will not be shared, sold, traded, exchanged or rented. See our [Privacy Policy](#) for more information.

Alliance Information

County of Residence* _____

County Alliance Affiliation* _____

Spouse's Name* _____

Spouse's Specialty _____

Physician's Medical Education (ME) number (for physician members only) _____

Credit Card Information

Check here if billing address is the same as home address

Name as it appears on credit card* _____

Address* _____

City* _____ State* _____ ZIP Code* _____

Credit Card # * _____

Card Type* Amex Visa MC

Card Number* _____ Expiration date* _____

Security Code (CID) * _____

Cardholder signature* _____

If paying by check, make it out to the American Medical Association Alliance and please send along with the completed form to:

American Medical Association Alliance

515 N State St. 9th Floor
Chicago, IL 60654