Society for Maternal-Fetal Medicine

International Application for SMFM Membership

Fill in this information and hit SUBMIT at the bottom of the page. Your membership will be processed within 48 hours and you will be contacted via email with a confirmation.

CONTACT INFORMATION

Last Name: First Name: Degree(s):

Current Hospital/Practice

Address:

City: State/Province:

Country: Select Your Country Postal Code:

* MEDICAL EDUCATION*2

University: Location: Dates (from/to):

*RESIDENCY TRAINING*2

Hospital: Location: Dates (from/to):

*FELLOWSHIP/POSTGRADUATE*2

Hospital: Location: Dates (from/to):

☐ Maternal-Fetal Medicine ☐ Critical Care Medicine ☐ Genetics ☐ Infectious Disease

☐ Other

BOARD CERTIFICATION (if applicable)

Year certified:

Maternal-Fetal Medicine: Genetics: Critical Care Medicine: Infectious Disease:

MEMBERSHIP

Country:

Select Your Country

Payment ☐ Visa ☐ MC ☐ AmEX ☐

Card Number:

Expiration Date: Security Code:

Name (as it appears on card):

Billing Address for Card:

City, State/Province, Zip Code:

Complete the membership applicaiton and email it to: smfm@smfm.org or mail it to:
Society for Maternal-Fetal Medicine
409 12th Street, SW Suite 601
Washington, DC 20024

If you have any questions contact Tim Heinle: theinle@smfm.org or 202-5176353