



Federation of Andhra Pradesh Medical Graduates in USA (APMGUSA)

148 Hawthorne Dr., Brooklyn, MI 49230
(517) 592-3109

www.apmgusa.org

A Not for Profit Organization Tax I.D. #01-0822348

MEMBERSHIP APPLICATION

MEMBERSHIP #: _____ DATE: _____
For Office Use Only

NAME: _____ SEX: M / F
Last First M.I. Email

MEDICAL COLLEGE: _____ YEAR OF GRADUATION: _____

SPECIALTY: _____ BOARD CERTIFIED? Y N

ADDITIONAL DEGREES: _____ MARTIAL STATUS: M S

HOME ADDRESS: _____ CITIZEN OF: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE # (H): _____ (O): _____ (C): _____

OFFICE ADDRESS: _____

CITY(O): _____ STATE(O): _____ ZIP: _____

SPOUSE'S FIRST NAME: _____ IS SPOUSE M.D.? Y N

COLLEGE IF M.D.: _____ SPECIALTY IF M.D.: _____

MEMBERSHIP CATEGORIES: ALUMNI ASSOCIATION: _____ INDIVIDUAL: _____

NAME OF THE ALUMNI ASSOCIATION: (IF APPLICABLE): _____

NAME OF UNIVERSITY AFFILIATION IF ANY _____ TITLE: _____

ENCLOSED IS MY MEMBERSHIP DUES: INDIVIDUAL: <input type="checkbox"/> \$100 LIFE <input type="checkbox"/> \$1000 PATRON	
ALUMNI ASSOCIATIONS ONLY: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000	
GENERAL DONATIONS TO APMGUSA: TOWARDS: _____ AMOUNT _____	
DONATION TO APMGUSA SPONSORED PROJECTS:	
<input type="checkbox"/> CME PROGRAMS \$ _____	<input type="checkbox"/> MEDICAL EDUCATION IN A.P. COLLEGES \$ _____
<input type="checkbox"/> RURAL HEALTH CARE/CAMPS IN A.P. \$ _____	<input type="checkbox"/> CHARITABLE PROJECT IN A.P./USA \$ _____
<input type="checkbox"/> ADOPT A VILLAGE IN A.P. \$ _____	<input type="checkbox"/> OTHER: DESCRIBE _____ \$ _____
For additional information, please visit our website www.apmgusa.org	

I HEREWITH ABIDE BY THE CONSTITUTION AND BYLAWS OF APMGUSA

SIGNED _____

To Pay By Credit Card, please fill out following information:	
Type of Card : <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> American Express	
Credit Card Number _____	Exp Date: _____
Credit Card Holders Name: _____	Signature: _____
Credit Card Billing address: (If Different from above) _____	
<input type="checkbox"/> I agree to pay the above total amount in US dollars according to card issuer agreement.	
Please mail this application (if paying by check payable to "APMGUSA") to:	APMGUSA 5723 Westshore Dr., Newport Richey, FL 34652

Revised: Aug, 08



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APMGUSA FOUNDATION PROJECT SPONSORSHIP FORM

Date Recvd : _____ Aprvd : _____

Read instructions carefully before you complete this form, Make checks payable to APMGUSA

Sponsor/s: _____ SS# (Tax ID): _____

Name/s: _____ Phone: _____

Address: _____

E-Mail: _____

Beneficiary Organization: _____

Is it Registered: Yes / No Is it non-profit: Yes / No

Coordinator's (Name in India): _____ Phone: _____

Address: _____

PROJECT DESCRIPTION:

- | | |
|---|-----------------|
| • CLEAN DRINKING WATER PLANT | \$ _____ |
| • BASIC HEALTH SCREENING | \$ _____ |
| • ENDOSCOPY/HEALTH SCREENING BY SPECIALISTS | \$ _____ |
| • CANCER SCREENING | \$ _____ |
| • CPR COURSE (ONE DAY) | \$ _____ |
| • ACLS PROVIDER COURSE (TWO DAYS) | \$ _____ |
| • IMMUNIZATION / OTHER PUBLIC HEALTH PROJECTS | \$ _____ |
| • CME PROGRAMS IN INDIA/USA | \$ _____ |
| • OTHERS (DESCRIBE:) _____ | \$ _____ |
| TOTAL | \$ _____ |

Name of Village: _____ Approximate Population Served: _____

Community benefits from the proposed project/s: _____

Project Expense: \$ _____

Beneficiary Contribution: \$ _____

Sponsor's Contribution: \$ _____

Of the total money donated by me, I understand that 2.5% will be utilized towards the charitable projects initiated by APMGUSA. As a sponsoring donor of funds, do you have any or intend to exercise any control or influence on the recipient organization and its implementation of the proposed community projects? **Yes / No**

What proposal do you have to ensure APMGUSA that the proposed project will be completed as planned by the recipient organization? Include any of your prior experience with the organization in carrying out other special programs, if any. As a sponsor who is familiar with the recipient organization and its members, can you assure APMGUSA that the beneficiary organization will submit quarterly progress report and financial report and the final report within three months of the completion of the project? **Yes / No**

Upon completion of this project, are you and the beneficiary organization willing to acknowledge the APMGUSA permanently on a plaque or in another suitable way for its help with the completion of the project? **Yes / No**

I/We am/are convinced that the beneficiary organization has the ability, experience and total commitment for the success of the project. I/We hereby declare that I/We have no personal benefit from this project. I/We are confident that the funds being contributed by me/us will be utilized for the stipulated use by the recipient org.

I/We understand that I/We am/are responsible for submitting to the APMGUSA the quarterly reports of work in the progress including photographs and of spending of funds. I/We understand that the tax-deductibility of my/our contributions may be in jeopardy if the funds are used for purposes other than the stipulated use by the recipient. Unless otherwise specifically approved by the Foundation Board, total sponsor's contribution towards a project shall not exceed \$50000. Contributions exceeding \$50000 may be approved, only after reviewing the progress reports

Sponsor's Signature: _____ Date: _____

Sponsor's Signature: _____ Date: _____

Revised: Aug, 08