Society of Refugee Healthcare Providers

Registration Form

Please complete this form and mail with check to the address below. We will manually enter you into our system and send you a confirmation email with a login and password for our website. You can update your remaining personal information directly on the website once you receive that login.

Name _____
First Last

Telephone Number _____

Email _____

Indicate membership level:

Circle one: New Member Renewal

- ☐ Physician - $175 USD Annually
- ☐ Medical Resident/Fellow - $125 USD Annually
- ☐ All Other - $100 USD Annually
- ☐ Student - $25 USD Annually (*Must include a copy of current and valid student ID.)

Send copy of student ID to info@nasrhp.org

Make check payable to *Society of Refugee Healthcare Providers* and mail registration form to:

Attn: Society of Refugee Healthcare Providers
Office of Community Medicine
222 Alexander Street Suite 2500
Rochester, NY 14613