EmpowerMED Membership Application

Please complete all fields below. This form is used to help us learn more about your goals, interests, and how we can support your journey into the world of medicine and healthcare.

Student Information

First Name: _____

Last Name: _____

Date of Birth: _____ Age: _____

School Name: _____

Grade Level: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____

Parent/Guardian Name: _____

Parent/Guardian Phone: _____

Emergency Contact Name & Phone: _____

Short Answer Questions

1. Why do you want to join EmpowerMED?

_____

_____

_____

2. What field of medicine or healthcare are you most interested in and why?

_____

_____

_____

3. What do you hope to gain from being a part of EmpowerMED?

_____

_____

_____

4. What do you feel you can contribute to the EmpowerMED community?

_____

_____

_____

5. Have you had any previous exposure to the medical field? If so, please describe.

_____

_____

_____

Acknowledgment

I certify that the information provided is accurate and true to the best of my knowledge.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____