Foreign Medical Program
Solidaridad Sin Fronteras Inc.
Registration form

Personal Information

Last Name	First Name	MI	
Street address			
City		State **FL**	Zip
Home phone number	Other phone number	E-mail address	
Birth Date (*mm-dd-yy*) / /	Social security number - -	***- or -***	Driver's license number - - - -

Education

Foreign License in:	Graduated		Name of University or College
Select One ...	Year:	Country:	

Voluntary Membership

☐ CHECK HERE If you choose to be a Voluntary Member of Solidaridad sin Fronteras.

I understand and accept the regular voluntary contribution of $10.00 USD per month, that will be used to financially support programs and projects from Solidaridad sin Fronteras. I have the option of paying:

○ 1 Month = $10.00 ○ 3 Month = $30.00 ○ 6 Month = $60.00 ○ 12 Month = $120.00

I am mailing the Registration form with check or money order payable to the **Solidaridad sin Fronteras** in the amount of: $ _____ to the address **P.O Box 832814 Miami, FL 33283.**

I HAVE READ AND UNDERSTAND THE POLICY STATEMENTS AND AGREE TO BE A VOLUNTARY MEMBER OF SOLIDARIDAD SIN FRONTERAS, INC.

_____ Signature

_____ Date