

**IPAC**  
Indigenous Physicians  
Association of Canada



**AMIC**  
Association de médecins  
indigènes du Canada

## IPAC Membership Renewal Opt In Form

By filling out this form, I confirm that:

- I am a current medical student and an IPAC student member.
- I consent to having my IPAC membership automatically renewed each year for the duration of my program, until such time that I graduate or opt out of my IPAC membership.

Full Name: \_\_\_\_\_

Date: \_\_\_\_\_

School: \_\_\_\_\_

Anticipated Graduation Year: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_