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: _____