



# Journal of Medical Research and Innovation

Membership form

## Name \*

First Name

Last Name

## Email \*

example@example.com

## Phone Number \*

Area Code

Phone Number

## Address \*

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

## Affiliation \*

## Field? \*

Membership period: 1 year from the payment date.

**By submitting this form, you are agreeing to our terms and conditions and privacy policy and by continuing you are agreeing to these. Please read these on <https://jmrionline.com/jmri/instructions> and <https://jmrionline.com/jmri/membership>. \***

YES

NO