



Alumni Information Sheet

Name: _____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

FAX: _____

E-Mail: _____

Professional Status (check one only)

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Practice | <input type="checkbox"/> Residency | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Academic Practice | <input type="checkbox"/> Fellowship | |
| <input type="checkbox"/> Military | <input type="checkbox"/> Retired | _____ |

Specialty: _____

Work Organization Name: _____

Work Address: _____

Work City, State: Zip: _____

Work County: _____

Spouse/Partner: _____

Please mail to Office of Alumni Affairs
 SIU School of Medicine
 P.O. Box 19604 Springfield, IL 62794-9604 or fax to 217-545-2024