



## EMPLOYMENT HISTORY

Name of Employer	Employment Dates		Summarize the Type of Work Performed and Job Responsibilities
Address	From	To	
Job Title			

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### ADDITIONAL INFORMATION: (The following information will assist us in determining your exam preparation needs).

Have you previously attended a formal review class?  YES  NO If YES, please list the following:

Name of Review Center: \_\_\_\_\_ City / State: \_\_\_\_\_

List any expectations you may have regarding "live" review class instructions?

\_\_\_\_\_

List your weakest subject(s) that you would like more instruction focus.

\_\_\_\_\_

List your strongest subject(s).

\_\_\_\_\_

Please tell us how you heard of our review programs:  Advertisement  Website  Search Engine \_\_\_\_\_

Friend \_\_\_\_\_  School \_\_\_\_\_

**Note: All information provided herein shall be handled in strict confidence and used solely for American Medical Academy's enrollment purposes and educational review program curriculum**

**Signature:** \_\_\_\_\_

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

Please print and mail completed registration with a check for the amount of **\$950**. to:

Checks should be made payable to:  
**AMERICAN MEDICAL ACADEMY**

American Medical Academy  
One World Trade Center, Suite #800  
Long Beach, CA 90831

For additional inquiries, please contact us at: **866-406-9522 / 562-936-0062** or [info@AmericanMedicalAcademy.org](mailto:info@AmericanMedicalAcademy.org)  
You may also visit our website at: [www.AmericanMedicalAcademy.org](http://www.AmericanMedicalAcademy.org)