

AAHPM Membership Application

Join AAHPM online at aahpm.org, or mail or fax this completed application to AAHPM, PO Box 3781, Oak Brook, IL, 60522-3781, fax 847.375.6475.

Name _____ Professional Credentials _____

Title _____ Preferred Mailing Address Office Home

Institution _____

Street Address _____ City/State/ZIP _____

Home Address _____ City/State/ZIP _____

Telephone: Home _____ Office _____

E-mail Address _____ Fax _____

Type of Membership

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Application Fee \$50
Required for new members | <input type="checkbox"/> Fellow \$180
Fellow who currently is in a fellowship program with an accredited institution; documentation must be provided from the current fellowship program director | <input type="checkbox"/> Student \$50
Full-time medical, nursing, pharmacy, or social work student with documentation from the dean of the program; this is a virtual membership (electronic access only) |
| <input type="checkbox"/> Physician \$535
Practicing physician who holds an MD, DO, or equivalent degree | <input type="checkbox"/> Resident \$50
Resident with documentation from the dean of the program; this is a virtual membership (electronic access only) | <input type="checkbox"/> International Corresponding \$30
Practicing physician who holds an MD, DO, or equivalent degree who resides in a developing nation (defined by the World Bank as "lower or middle income"); this is a virtual membership (electronic access only) |
| <input type="checkbox"/> Affiliate \$295
Nurse, physician assistant, social worker, pharmacist, or other nonphysician health-care professional | | |

Demographics

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Degree
<input type="checkbox"/> DO
<input type="checkbox"/> MD
<input type="checkbox"/> Nonphysician/Other _____ | Primary Work Setting
<input type="checkbox"/> Academic Hospital/Teaching Center
<input type="checkbox"/> Clinical Private Practice
<input type="checkbox"/> Community-Based Palliative Care
<input type="checkbox"/> Government
<input type="checkbox"/> Home Health Agency
<input type="checkbox"/> Hospice
<input type="checkbox"/> Hospital-Based Palliative Care
<input type="checkbox"/> Hospital/Medical Center
<input type="checkbox"/> Long-Term Care Facility
<input type="checkbox"/> Other _____ | Primary Position
<input type="checkbox"/> Academia—Faculty
<input type="checkbox"/> Academia—Fellowship Director
<input type="checkbox"/> Chaplain
<input type="checkbox"/> Chief Medical Officer
<input type="checkbox"/> Hospice Medical Director
<input type="checkbox"/> Hospice Physician
<input type="checkbox"/> NP/APN/Advanced Nursing Degree
<input type="checkbox"/> Nurse
<input type="checkbox"/> Pharmacist
<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Social Worker
<input type="checkbox"/> Physician Other _____
<input type="checkbox"/> Nonphysician Other _____ |
| Primary Board Specialty
<input type="checkbox"/> Anesthesiology
<input type="checkbox"/> Emergency Medicine
<input type="checkbox"/> Family Medicine
<input type="checkbox"/> Internal Medicine
<input type="checkbox"/> Obstetrics and Gynecology
<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Physical Medicine and Rehabilitation
<input type="checkbox"/> Psychiatry and Neurology
<input type="checkbox"/> Radiology
<input type="checkbox"/> Surgery
<input type="checkbox"/> Physician Other _____
<input type="checkbox"/> Nonphysician Other _____ | Primary Responsibility
<input type="checkbox"/> Academic
<input type="checkbox"/> Clinical
<input type="checkbox"/> Management/Leadership
<input type="checkbox"/> Quality
<input type="checkbox"/> Research | |

Visit aahpm.org to complete your member profile.

Payment

Mastercard Visa American Express Discover

Check enclosed (payable to AAHPM; must be in US funds. A \$25 charge will apply to checks returned for insufficient funds.)

Account number _____ Expiration date _____

Signature _____ Cardholder's name (please print) _____

Consult your tax adviser for information on dues deductibility.