AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

international membership application

FOR OFFICE USE ONLY

You can also apply for membership online at www.aafp.org/intlapp.

ARE YOU A PREVIOUS MEMBER OF THE AAFP? ☐ YES ☐ NO

IF YES, PREVIOUS AAFP MEMBER ID (IF KNOWN) _____

PERSONAL INFORMATION

NAME (FIRST) _____

(MIDDLE) _____

(LAST) _____ (SUFFIX) _____

(PREVIOUS LAST NAME, IF APPLICABLE) _____

DEGREE (MD/DO/MBBS/MBChB, ETC) _____

DATE OF BIRTH (MM) _____ (DD) _____ (YYYY) _____

☐ MALE ☐ FEMALE ☐ TRANSGENDER ☐ OTHER ☐ PREFER NOT TO ANSWER

BUSINESS

☐ PLEASE INDICATE WITH A CHECK MARK IF THIS IS YOUR PREFERRED MAILING ADDRESS FOR RECEIVING INFORMATION AND SUBSCRIPTIONS FROM THE AAFP.

PRACTICE/BUSINESS NAME

_____

STREET ADDRESS

_____

_____

CITY _____

STATE _____ ZIP _____

PROVINCE _____ COUNTRY _____

BUSINESS PHONE (_____)_____

BUSINESS FAX (_____)_____

HOME

☐ PLEASE INDICATE WITH A CHECK MARK IF THIS IS YOUR PREFERRED MAILING ADDRESS FOR RECEIVING INFORMATION AND SUBSCRIPTIONS FROM THE AAFP.

STREET ADDRESS

_____

_____

CITY_____

STATE _____ ZIP _____

PROVINCE _____ COUNTRY _____

HOME PHONE (_____)_____

PHONE NUMBER(S)

☐ PLEASE INDICATE WITH A CHECK MARK IF THIS IS YOUR PREFERRED MAILING ADDRESS FOR RECEIVING INFORMATION AND SUBSCRIPTIONS FROM THE AAFP.

☐ BUSINESS (_____)_____

☐ HOME (_____)_____

☐ CELL (_____)_____

EMAIL ADDRESS

EMAIL _____

(PLEASE NOTE THAT FOR CERTAIN MEMBER BENEFITS, YOU MUST PROVIDE A WORKING EMAIL ADDRESS IN ORDER TO RECEIVE THEM.)

TWITTER HANDLE

TWITTER HANDLE @_____

EDUCATION

MEDICAL SCHOOL

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

PROVINCE _____

COUNTRY_____

DEGREE_____

START DATE _____
(MM/DD/YYYY)

GRADUATION DATE _____
(MM/DD/YYYY)

FAMILY MEDICINE RESIDENCY PROGRAM

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

PROVINCE _____

COUNTRY_____

START DATE _____
(MM/DD/YYYY)

RESIDENCY COMPLETION DATE _____
(MM/DD/YYYY)

FELLOWSHIP/ADDITIONAL TRAINING (IF APPLICABLE)

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

PROVINCE _____

COUNTRY_____

EMPHASIS_____

FELLOWSHIP COMPLETION DATE _____
(MM/DD/YYYY)

OTHER TRAINING (IF APPLICABLE)

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE_____

COUNTRY_____

EMPHASIS_____

COMPLETION DATE_____
(MM/DD/YYYY)

(Additional information on back) 10/18

international membership application

PROFESSIONAL INFORMATION

MEDICAL LICENSE # _____

STATE/PROVINCE _____

COUNTRY _____

ISSUANCE DATE _____ (MM/DD/YYYY) EXPIRATION DATE _____ (MM/DD/YYYY)

NAME OF OTHER LICENSING AUTHORITY _____

IF YOU DO NOT HAVE A CURRENT ACTIVE MEDICAL LICENSE WHERE YOU PRACTICE, PLEASE EXPLAIN. (ATTACH A SEPARATE PAGE IF NECESSARY TO FULLY EXPLAIN.)

_____

_____

ARE YOU NOW ENGAGED IN FAMILY MEDICINE, TEACHING FAMILY MEDICINE, OR ENGAGED IN MEDICAL ADMINISTRATION? ☐ YES ☐ NO

SIGNATURE/CERTIFICATION

In signing this application, I certify that the above information is correct and complete and do hereby agree to abide by the bylaws of the American Academy of Family Physicians and the bylaws of my constituent chapter, if applicable. I understand that by providing my mailing address, email address, telephone numbers, and fax number, I consent to receive communications sent by or on behalf of the AAFP and its chapters and affiliates via regular mail, email, telephone, or fax.

SIGNATURE _____

DATE _____

PAYMENT

PAYMENT OF DUES IS REQUIRED BEFORE YOUR MEMBERSHIP WILL BE ACTIVATED. TO EXPEDITE YOUR MEMBERSHIP, YOU MAY PAY YOUR MEMBERSHIP DUES BY CREDIT CARD VIA THIS APPLICATION; YOUR CARD WILL BE CHARGED FOR THE FULL AMOUNT OF DUES AT THE ANNUAL RATE OF U.S. $120. IF YOU HAVE ANY QUESTIONS ABOUT THE APPLICATION PROCESS, PLEASE CALL THE AAFP MEMBER RESOURCE CENTER AT (913) 906-6000.

SELECT PAYMENT METHOD

CHECKS MUST BE IN U.S. FUNDS DRAWN ON A U.S. BANK.

- ☐ CHECK ENCLOSED
- ☐ AMEX
- ☐ DISCOVER
- ☐ MASTERCARD
- ☐ VISA

CARD # _____

EXPIRATION DATE _____ (MM/YYYY)

SECURITY CODE/CVV# _____

CARD HOLDER'S NAME _____

CARD HOLDER'S SIGNATURE _____

PLEASE SEND COMPLETED APPLICATION AND PAYMENT TO:

American Academy of Family Physicians
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2680

Phone: (913) 906-6000
Fax: (913) 906-6075
aafp.org