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)

international membership application

PROFESSIONAL INFORMATION

MEDICAL LICENSE # ______________________________

STATE/PROVINCE______________________________

COUNTRY______________________________

ISSUANCE DATE______________ (MM/DD/YYYY) EXPIRATION DATE______________ (MM/DD/YYYY

NAME OF OTHER LICENSING AUTHROITY______________________________

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. 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 subsidiaries 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