# resident membership application

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

ARE YOU A PREVIOUS MEMBER OF THE AAFP? ☐ YES ☐ NO   IF YES, PREVIOUS AAFP ID (IF KNOWN)?________________________

## PERSONAL INFORMATION

NAME (FIRST) ____________________

(MIDDLE) ____________________

(LAST) ____________________ (SUFFIX) ________

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

PREVIOUS NAME (IF APPLICABLE) ____________________

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.

OFFICE/PRACTICE/INSTITUTION NAME

____________________

STREET ADDRESS

____________________

CITY____________________

STATE ____________________ ZIP ________

BUSINESS PHONE (________)____________________

## 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 ________

HOME PHONE (________)____________________

## PHONE NUMBER(S)

PLEASE INDICATE WITH A CHECK MARK YOUR PREFERRED PHONE NUMBER.

☐ 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 ________@____________________

## TEXT MESSAGE OPT-IN

☐ I AGREE TO RECEIVE TEXT MESSAGE ALERTS ON A LIMITED BASIS FROMTHE AAFP—UP TO ONE MESSAGE PER MONTH—REGARDING MY MEMBERSHIP STATUS, DUES, OR OTHER TIME-SENSITIVE NOTIFICATIONS.

CELL PHONE (________)____________________

## MEDICAL SCHOOL EDUCATION

NAME____________________
*(PLEASE DO NOT ABBREVIATE)*

CITY ____________________

STATE ____________________ COUNTRY ____________________

DEGREE____________________

START DATE (MM) ________ (DD) ________ (YYYY) ________

GRADUATION DATE (MM) ________ (DD) ________ (YYYY) ________

## FAMILY MEDICINE RESIDENCY PROGRAM

NAME____________________
*(PLEASE DO NOT ABBREVIATE)*

CITY ____________________ STATE ________

RESIDENCY START DATE (MM) ________ (DD) ________ (YYYY) ________

RESIDENCY COMPLETION DATE (MM) ________ (DD) ________ (YYYY) ________

## POST-RESIDENCY FELLOWSHIP (IF APPLICABLE)

NAME____________________
*(PLEASE DO NOT ABBREVIATE)*

CITY ____________________ STATE ________

EMPHASIS ____________________

FELLOWSHIP COMPLETION DATE (MM) ________ (DD) ________ (YYYY) ________

## PROFESSIONAL

MEDICAL LICENSE NO. ____________________

STATE____________________ COUNTRY____________________

ISSUANCE DATE____________________ EXPIRATION DATE____________________

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 ACTIVE MILITARY? ☐ YES ☐ NO

## LONGITUDINAL STUDY

THE AAFP IS COLLECTING HIGH SCHOOL CITY, STATE, AND COUNTRY DATA TO BE UTILIZED FOR A LONGITUDINAL STUDY CONCERNING PHYSICIAN WORKFORCE.

HIGH SCHOOL CITY ____________________ STATE ________

COUNTRY ____________________

## 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** ____________________

*(Additional information on back)*

# 2017-2018
# AAFP Resident Dues Information

**DO NOT SEND MONEY WITH YOUR APPLICATION.**
Upon approval of your membership, you will receive an invoice.
If you have any questions, please contact the AAFP at (800) 274-2237.

| CHAPTER | AAFP | CHAPTER | TOTAL |
|---|---|---|---|
| Alabama | $30 | $20 | $50 |
| Alaska | $30 | $0 | $30 |
| Arizona | $30 | $0 | $30 |
| Arkansas | $30 | $65 | $95 |
| California | $30 | $10 | $40 |
| Colorado | $30 | $10 | $40 |
| Connecticut | $30 | $15 | $45 |
| Delaware | $30 | $0 | $30 |
| District of Columbia | $30 | $0 | $30 |
| Florida | $30 | $10 | $40 |
| Georgia | $30 | $25 | $55 |
| Hawaii | $30 | $0 | $30 |
| Idaho | $30 | $0 | $30 |
| Illinois | $30 | $15 | $45 |
| Indiana | $30 | $20 | $50 |
| Iowa | $30 | $10 | $40 |
| Kansas | $30 | $0 | $30 |
| Kentucky | $30 | $0 | $30 |
| Louisiana | $30 | $15 | $45 |
| Maine | $30 | $0 | $30 |
| Maryland | $30 | $20 | $50 |
| Massachusetts | $30 | $0 | $30 |
| Michigan | $30 | $20 | $50 |
| Minnesota | $30 | $10 | $40 |
| Mississippi | $30 | $0 | $30 |
| Missouri | $30 | $10 | $40 |
| Montana | $30 | $0 | $30 |

| CHAPTER | AAFP | CHAPTER | TOTAL |
|---|---|---|---|
| Nebraska | $30 | $5 | $35 |
| Nevada | $30 | $0 | $30 |
| New Hampshire | $30 | $0 | $30 |
| New Jersey | $30 | $10 | $40 |
| New Mexico | $30 | $0 | $30 |
| New York | $30 | $25 | $55 |
| North Carolina | $30 | $35 | $65 |
| North Dakota | $30 | $0 | $30 |
| Ohio | $30 | $0 | $30 |
| Oklahoma | $30 | $25 | $55 |
| Oregon | $30 | $10 | $40 |
| Pennsylvania | $30 | $0 | $30 |
| Puerto Rico | $30 | $0 | $30 |
| Rhode Island | $30 | $0 | $30 |
| South Carolina | $30 | $0 | $30 |
| South Dakota | $30 | $0 | $30 |
| Tennessee | $30 | $12.50 | $42.50 |
| Texas | $30 | $10 | $40 |
| Utah | $30 | $20 | $50 |
| Vermont | $30 | $0 | $30 |
| Virginia | $30 | $25 | $55 |
| Washington | $30 | $0 | $30 |
| West Virginia | $30 | $0 | $30 |
| Wisconsin | $30 | $0 | $30 |
| Wyoming | $30 | $0 | $30 |
| Uniformed Services | $30 | $0 | $30 |

**NOTE:** A portion of your AAFP dues is not deductible as an ordinary and necessary business expense to the extent that the AAFP engages in lobbying. Please go to www.aafp.org/duesdeduct to learn what portion of your AAFP national and chapter dues are not deductible.

**PLEASE SEND YOUR COMPLETED APPLICATION TO:**

AAFP


**American Academy of Family Physicians**
**11400 Tomahawk Creek Parkway**
**Leawood, KS 66211-2680**
**Phone: (800) 274-2237**
**Fax: (913) 906-6075**
**aafp.org**


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