AAFP
STRONG MEDICINE FOR AMERICA

supporting membership application

FOR OFFICE USE ONLY

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

SUPPORTING MEMBERS SHALL BE:

1. Physicians residing and practicing in the United States (or its territories or possessions) who completed an ACGME- or AOA-accredited residency program in specialties other than family medicine and not otherwise eligible for some other category of membership; or
2. Physicians who previously held supporting membership before September 30, 2016.

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

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

PERSONAL INFORMATION

FIRST NAME _____

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 _____ COUNTY _____

BUSINESS PHONE (_____) _____

BUSINESS FAX (_____) _____

EMPLOYER/PARENT ORGANIZATION

EMPLOYER/PARENT ORGANIZATION NAME

_____

STREET ADDRESS _____

_____

CITY _____

STATE _____ ZIP _____ COUNTRY _____

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 _____ COUNTY _____

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 FROM THE AAFP—UP TO ONE MESSAGE PER MONTH—REGARDING MY MEMBERSHIP STATUS, DUES, OR OTHER TIME-SENSITIVE NOTIFICATIONS.

CELL PHONE (_____) _____

EDUCATION

MEDICAL SCHOOL

NAME _____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE _____

COUNTRY _____

DEGREE _____

START DATE _____
(MM/DD/YYYY)

GRADUATION DATE _____
(MM/DD/YYYY)

(Additional information on back)

AAFP supporting membership application

STRONG MEDICINE FOR AMERICA

EDUCATION CONTINUED

RESIDENCY PROGRAM

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE_____

SPECIALTY_____

START DATE_____
(MM/DD/YYYY)

RESIDENCY COMPLETION DATE _____
(MM/DD/YYYY)

FELLOWSHIP/ADDITIONAL TRAINING (IF APPLICABLE)

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE_____

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)

PROFESSIONAL INFORMATION

LICENSURE

MEDICAL LICENSE # _____

STATE_____ COUNTRY_____

ISSUANCE DATE_____ EXPIRATION DATE_____
(MM/DD/YYYY) *(MM/DD/YYYY)*

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

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. IF THE CONSTITUENT CHAPTER YOU AFFILIATE WITH INCLUDES A LOCAL CHAPTER (A LOCAL CHAPTER MAY EXIST IN A PARTICULAR COUNTY OR REGION OF THE STATE IN WHICH YOU PRACTICE OR RESIDE), DUES WILL VARY. 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 NATIONAL DUES, CHAPTER DUES, AND LOCAL CHAPTER DUES (IF APPLICABLE) AT THE RATES SHOWN ON THE FOLLOWING PAGE UPON FINAL APPROVAL OF YOUR APPLICATION. IF YOU HAVE ANY QUESTIONS ABOUT THE APPLICATION PROCESS OR WOULD LIKE TO KNOW THE EXACT COST OF YOUR MEMBERSHIP DUES, PLEASE CALL THE AAFP MEMBER RESOURCE CENTER AT (800) 274-2237.

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: (800) 274-2237
Fax: (913) 906-6075
aafp.org

2017 AAFP Supporting Dues Information

CHAPTER	AAFP	CHAPTER	LOCAL	TOTAL		Dues Total if After July 1
Alabama	$270	$275		$545		$272.50
Alaska	$270	$250		$520		$260
Arizona	$270	$325		$595		$297.50
Arkansas	$270	$250		$520		$260
California	$270	$265	$0 – $60	$535 – $595		$267.50 – $297.50
Colorado	$270	$220		$490		$245
Connecticut	$270	$325		$595		$297.50
Delaware	$270	$125		$395		$197.50
District of Columbia	$270	$210		$480		$240
Florida	$270	$200		$470		$235
Georgia	$270	$300		$570		$285
Guam	$270	$10		$280		$140
Hawaii	$270	$160		$430		$215
Idaho	$270	$295		$565		$282.50
Illinois	$270	$305		$575		$287.50
Indiana	$270	$365		$635		$317.50
Iowa	$270	$235		$505		$252.50
Kansas	$270	$310		$580		$290
Kentucky	$270	$350	$0 – $30	$620 – $650		$310 – $325
Louisiana	$270	$320		$590		$295
Maine	$270	$115		$385		$192.50
Maryland	$270	$395		$665		$332.50
Massachusetts	$270	$295		$565		$282.50
Michigan	$270	$250	$0 – $25	$520 – $545		$260 – $272.50
Minnesota	$270	$250	$0 – $15	$520 – $535		$260 – $267.50
Mississippi	$270	$275		$545		$272.50
Missouri	$270	$125	$0 – $100	$395 – $495		$197.50 – $247.50
Montana	$270	$100		$370		$185
Nebraska	$270	$180		$450		$225
Nevada	$270	$150		$420		$210
New Hampshire	$270	$100		$370		$185
New Jersey	$270	$295	$0 – $10	$565 – $575		$282.50 – $287.50
New Mexico	$270	$280		$550		$275
New York	$270	$255	$0 – $50	$525 – $575		$262.50 – $287.50
North Carolina	$270	$330		$600		$300
North Dakota	$270	$125		$395		$197.50
Ohio	$270	$399	$0 – $20	$669 – $689		$334.50 – $344.50
Oklahoma	$270	$275		$545		$272.50
Oregon	$270	$285		$555		$277.50
Pennsylvania	$270	$255		$525		$262.50
Puerto Rico	$270	$0		$270		$135
Rhode Island	$270	$150		$420		$210
South Carolina	$270	$285		$555		$277.50
South Dakota	$270	$125		$395		$197.50
Tennessee	$270	$335		$605		$302.50
Texas	$270	$225	$0 – $130	$495 – $625		$247.50 – $312.50
Utah	$270	$100		$370		$185
Vermont	$270	$30		$300		$150
Virgin Islands	$270	$10		$280		$140
Virginia	$270	$225	$0 – $25	$495 – $520		$247.50 – $260
Washington	$270	$310	$0 – $75	$580 – $655		$290 – $327.50
West Virginia	$270	$275		$545		$272.50
Wisconsin	$270	$318		$588		$294
Wyoming	$270	$25		$295		$147.50
Uniformed Services	$270	$50		$320		$160

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.

AAFP
STRONG MEDICINE FOR AMERICA

11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680

Apply today for the membership that supports you and your profession!