



international membership application

FOR OFFICE USE ONLY

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

DATE OF APPLICATION

(MM) _____ (DD) _____ (YYYY) _____

ARE YOU A PREVIOUS MEMBER OF THE AAFP? YES NO

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

IF YES, WHAT WAS YOUR PREVIOUS AAFP MEMBERSHIP TYPE?

STUDENT RESIDENT ACTIVE SUPPORTING INACTIVE

IF YES, APPROXIMATE DATE OF PREVIOUS MEMBERSHIP _____

CHAPTER AFFILIATION DURING PREVIOUS AAFP MEMBERSHIP

PERSONAL INFORMATION

NAME (FIRST) _____

(MIDDLE) _____

(LAST) _____ (SUFFIX) _____

(PREVIOUS LAST NAME, IF DIFFERENT) _____

DEGREE (MD/DO/PhD,ETC) _____

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

MALE FEMALE

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 _____

PROVINCE _____ COUNTRY _____

CELL PHONE (_____) _____

OFFICE PHONE (_____) _____

FAX (_____) _____

EMAIL _____

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

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 (_____) _____

CELL PHONE (_____) _____

EMAIL _____

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

EDUCATION

MEDICAL SCHOOL

NAME _____
(PLEASE DO NOT ABBREVIATE)

CITY _____

PROVINCE _____

COUNTRY _____

DEGREE _____

GRADUATION DATE/LEVEL OF TRAINING _____
(MM/DD/YYYY)

FAMILY MEDICINE RESIDENCY PROGRAM

NAME _____
(PLEASE DO NOT ABBREVIATE)

CITY _____

PROVINCE _____

COUNTRY _____

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)



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PROFESSIONAL INFORMATION

AAFP BYLAWS REQUIRE INTERNATIONAL MEMBERS TO BE LICENSED TO PRACTICE MEDICINE. PLEASE PROVIDE THE INFORMATION BELOW.

LICENSURE

LICENSE NO. _____

STATE/PROVINCE/COUNTRY _____

DATE ISSUED _____ EXPIRATION DATE _____

ARE YOU NOW ENGAGED IN FAMILY MEDICINE? YES NO

IF YES, DATE YOU ENTERED FAMILY MEDICINE _____
(MM/DD/YYYY)

WHICH OF THE FOLLOWING DESCRIBES YOUR PRACTICE? (PLEASE CHECK ALL THAT APPLY)

- CLINICAL PRACTICE
- TEACHING
- ADMINISTRATIVE

ARE YOU CURRENTLY IN TRAINING? 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, e-mail 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, e-mail, telephone, or fax. I understand that the AAFP will not share my e-mail address, telephone number, or fax number with other organizations.

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 US \$110. IF YOU HAVE ANY QUESTIONS ABOUT THE APPLICATION PROCESS, PLEASE CALL THE AAFP CONTACT 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 PROVIDER _____

EXPIRATION DATE _____
(MM/YYYY)

CARD # _____

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
www.aafp.org

FOR OFFICE USE ONLY

National Action: Approved Approval not recommended for applicant

REMARKS: _____

Chapter Action: Approved Approval not recommended for applicant

REMARKS: _____

Signature _____
(Constituent Chapter Officer)

Date _____

Signature _____
(Local/Component Chapter Officer)

Date _____