



# resident membership application

FOR OFFICE USE ONLY

You can also apply for membership online at [www.aafp.org/residentapp](http://www.aafp.org/residentapp).

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, APPROXIMATE DATE OF PREVIOUS MEMBERSHIP \_\_\_\_\_ CHAPTER AFFILIATION DURING PREVIOUS AAFP MEMBERSHIP \_\_\_\_\_  
(MM/DD/YYYY)

### PERSONAL INFORMATION

NAME (FIRST) \_\_\_\_\_

(MIDDLE) \_\_\_\_\_

(LAST) \_\_\_\_\_ (SUFFIX) \_\_\_\_\_

TITLE (MD/DO/PHD, ETC) \_\_\_\_\_

PREVIOUS NAME (IF APPLICABLE) \_\_\_\_\_

DATE OF BIRTH (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YYYY) \_\_\_\_\_

MALE  FEMALE

### BUSINESS/OTHER

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 \_\_\_\_\_ COUNTY \_\_\_\_\_

HOME 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 \_\_\_\_\_ COUNTY \_\_\_\_\_

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 \_\_\_\_\_

STATE \_\_\_\_\_

DEGREE \_\_\_\_\_

GRADUATION DATE/LEVEL OF TRAINING \_\_\_\_\_  
(MM/DD/YYYY)

#### FAMILY MEDICINE RESIDENCY PROGRAM

NAME \_\_\_\_\_  
(PLEASE DO NOT ABBREVIATE)

CITY \_\_\_\_\_

STATE \_\_\_\_\_

DEGREE \_\_\_\_\_

RESIDENCY COMPLETION DATE \_\_\_\_\_  
(MM/DD/YYYY)

#### POST-RESIDENCY FELLOWSHIP/ADDITIONAL TRAINING (IF APPLICABLE)

NAME \_\_\_\_\_  
(PLEASE DO NOT ABBREVIATE)

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ADDITIONAL QUALIFICATIONS/CERTIFICATIONS \_\_\_\_\_

FELLOWSHIP COMPLETION DATE \_\_\_\_\_  
(MM/DD/YYYY)

### PROFESSIONAL

LICENSE NO. \_\_\_\_\_

STATE \_\_\_\_\_

HAVE YOU EVER BEEN DENIED MEMBERSHIP IN A COUNTY OR STATE MEDICAL SOCIETY; HAD YOUR LICENSE SUSPENDED OR REVOKED; VOLUNTARILY SURRENDERED YOUR LICENSE; OR, BEEN CONVICTED OF A FELONY OR VIOLATION OF ANY STATE OR FEDERAL NARCOTICS ACT?  
 YES  NO

IF YES, PLEASE EXPLAIN (ATTACH A SEPARATE PAGE IF NECESSARY TO FULLY EXPLAIN)

### 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 \_\_\_\_\_

(Additional information on back)

# 2009-2010 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 AAFP at (800) 274-2237.

CHAPTER	AAFP	CHAPTER	TOTAL
Alabama	\$25	\$20	\$45
Alaska	\$25	\$0	\$25
Arizona	\$25	\$0	\$25
Arkansas	\$25	\$65	\$90
California	\$25	\$10	\$35
Colorado	\$25	\$10	\$35
Connecticut	\$25	\$15	\$40
Delaware	\$25	\$0	\$25
District of Columbia	\$25	\$0	\$25
Florida	\$25	\$10	\$35
Georgia	\$25	\$25	\$50
Hawaii	\$25	\$0	\$25
Idaho	\$25	\$0	\$25
Illinois	\$25	\$15	\$40
Indiana	\$25	\$20	\$45
Iowa	\$25	\$5	\$30
Kansas	\$25	\$0	\$25
Kentucky	\$25	\$0	\$25
Louisiana	\$25	\$15	\$40
Maine	\$25	\$0	\$25
Maryland	\$25	\$20	\$45
Massachusetts	\$25	\$0	\$25
Michigan	\$25	\$5	\$30
Minnesota	\$25	\$10	\$35
Mississippi	\$25	\$0	\$25
Missouri	\$25	\$10	\$35
Montana	\$25	\$0	\$25

CHAPTER	AAFP	CHAPTER	TOTAL
Nebraska	\$25	\$5	\$30
Nevada	\$25	\$0	\$25
New Hampshire	\$25	\$0	\$25
New Jersey	\$25	\$10	\$35
New Mexico	\$25	\$0	\$25
New York	\$25	\$15	\$40
North Carolina	\$25	\$35	\$60
North Dakota	\$25	\$0	\$25
Ohio	\$25	\$0	\$25
Oklahoma	\$25	\$25	\$50
Oregon	\$25	\$0	\$25
Pennsylvania	\$25	\$0	\$25
Puerto Rico	\$25	\$0	\$25
Rhode Island	\$25	\$0	\$25
South Carolina	\$25	\$0	\$25
South Dakota	\$25	\$0	\$25
Tennessee	\$25	\$12.50	\$37.50
Texas	\$25	\$10	\$35
Utah	\$25	\$15	\$40
Vermont	\$25	\$0	\$25
Virgin Islands	\$25	\$0	\$25
Virginia	\$25	\$25	\$50
Washington	\$25	\$0	\$25
West Virginia	\$25	\$0	\$25
Wisconsin	\$25	\$0	\$25
Wyoming	\$25	\$0	\$25
Uniformed Services	\$25	\$0	\$25

**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](http://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**  
**[www.aafp.org](http://www.aafp.org)**

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DATE STAMP

INITIALS