



# supporting membership family medicine application

FOR OFFICE USE ONLY

FP

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

**Important:** If you have held AAFP Active or Supporting family physician membership within the past two years, evidence of 100 CME credits earned during the past two years must also be submitted. Please submit your CME records along with your completed application to:

AAFP; Attn: Contact Center  
11400 Tomahawk Creek Parkway  
Leawood, KS 66211-2680.

You may also fax your CME records to Attn: Contact Center, (913) 906-6075.

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

EMAIL \_\_\_\_\_

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

## 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 \_\_\_\_\_ COUNTY \_\_\_\_\_

CELL PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

OFFICE PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

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

HOME PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

CELL PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

## EDUCATION

### MEDICAL SCHOOL

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

CITY \_\_\_\_\_

STATE \_\_\_\_\_

COUNTRY \_\_\_\_\_

DEGREE \_\_\_\_\_

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

### FAMILY MEDICINE RESIDENCY PROGRAM

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

CITY \_\_\_\_\_

STATE \_\_\_\_\_

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)



# supporting membership

## family medicine application

### PROFESSIONAL INFORMATION

#### LICENSURE

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

STATE \_\_\_\_\_

DATE ISSUED \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ARE YOU NOW ENGAGED IN FAMILY MEDICINE?  YES  NO

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

CURRENT PRACTICE ACTIVITIES (PLEASE CHECK ALL THAT APPLY)

- SOLO PRACTICE
- GROUP PRACTICE
- TEACHING
- RESEARCH
- ADMINISTRATIVE
- MILITARY / BRANCH \_\_\_\_\_
- GOVERNMENT (NON-MILITARY)
- OTHER \_\_\_\_\_

### 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. 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, CONSTITUENT 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 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, PAYMENT AND CME RECORDS (IF NECESSARY) 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 \_\_\_\_\_

# 2012 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	\$320		\$590	\$295
Arkansas	\$270	\$250		\$520	\$260
California	\$270	\$240	\$5 - \$50	\$515 - \$560	\$257.50 - \$280
Colorado	\$270	\$220		\$490	\$245
Connecticut	\$270	\$275		\$545	\$272.50
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	\$225		\$495	\$247.50
Illinois	\$270	\$305		\$575	\$287.50
Indiana	\$270	\$350	\$0 - \$15	\$635	\$317.50
Iowa	\$270	\$100		\$370	\$185
Kansas	\$270	\$275		\$545	\$272.50
Kentucky	\$270	\$350	\$0 - \$30	\$545 - \$575	\$272.50 - \$287.50
Louisiana	\$270	\$275		\$545	\$272.50
Maine	\$270	\$95		\$365	\$182.50
Maryland	\$270	\$320		\$690	\$345
Massachusetts	\$270	\$150		\$420	\$210
Michigan	\$270	\$165	\$0 - \$25	\$435 - \$460	\$217.50 - \$230
Minnesota	\$270	\$250	\$0 - \$15	\$520 - \$535	\$260 - \$267.50
Mississippi	\$270	\$250		\$520	\$260
Missouri	\$270	\$125	\$0 - \$40	\$395 - \$435	\$197.50 - \$217.50
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	\$230		\$500	\$250
New York	\$270	\$240	\$0 - \$50	\$510 - \$560	\$255 - \$280
North Carolina	\$270	\$320		\$590	\$295
North Dakota	\$270	\$100		\$370	\$185
Ohio	\$270	\$345	\$0 - \$20	\$615 - \$635	\$307.50 - \$317.50
Oklahoma	\$270	\$235	\$0 - \$75	\$505 - \$580	\$252.50 - \$290
Oregon	\$270	\$260		\$530	\$265
Pennsylvania	\$270	\$255		\$525	\$262.50
Puerto Rico	\$270	\$0		\$270	\$135
Rhode Island	\$270	\$125		\$395	\$197.50
South Carolina	\$270	\$240		\$510	\$255
South Dakota	\$270	\$125		\$395	\$197.50
Tennessee	\$270	\$325		\$595	\$297.50
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	\$275	\$0 - \$20	\$545 - \$565	\$272.50 - \$282.50
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](http://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!**