



# supporting membership (other specialty) application

FOR OFFICE USE ONLY

OTHER

### SUPPORTING MEMBERSHIP FOR PHYSICIANS IN OTHER SPECIALTIES

Licensed physicians in specialties other than family medicine who have demonstrated support of the specialty and meet criteria approved by the AAFP Board of Directors which includes:

1. Supporting the presence of family medicine departments in hospitals.
2. Supporting the proper privileging of family medicine physicians in hospitals and managed health care systems.
3. Working to help improve the status of Departments of Family Medicine in medical schools.
4. Fostering the principles and policies of family medicine among local, state and federal government bodies.
5. Demonstrated understanding of the strength and the effectiveness of the medical referral and consultation process inclusive of primary care physicians and focused specialty physicians.
6. Supporting family medicine residency programs regardless of location and site.

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

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

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)

(Additional information on back)



# 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 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 \_\_\_\_\_

# 2010 AAFP Supporting Dues Information

CHAPTER	AAFP	CHAPTER	LOCAL	TOTAL	Dues Total if After July 1
Alabama	\$260	\$275		\$535	\$267.50
Alaska	\$260	\$225		\$485	\$242.50
Arizona	\$260	\$305		\$565	\$282.50
Arkansas	\$260	\$225		\$485	\$242.50
California	\$260	\$240	\$0 - \$50	\$500 - \$550	\$250.00 - \$275.00
Colorado	\$260	\$160		\$420	\$210.00
Connecticut	\$260	\$250		\$510	\$255.00
Delaware	\$260	\$125		\$385	\$192.50
District of Columbia	\$260	\$210		\$470	\$235.00
Florida	\$260	\$200		\$460	\$230.00
Georgia	\$260	\$300		\$560	\$280.00
Guam	\$260	\$10		\$270	\$135.00
Hawaii	\$260	\$160		\$420	\$210.00
Idaho	\$260	\$200		\$460	\$230.00
Illinois	\$260	\$305		\$565	\$282.50
Indiana	\$260	\$350	\$15	\$610 - \$625	\$305.00 - \$312.50
Iowa	\$260	\$235		\$495	\$247.50
Kansas	\$260	\$50		\$310	\$155.00
Kentucky	\$260	\$350	\$0 - \$30	\$610 - \$640	\$305.00 - \$320.00
Louisiana	\$260	\$275		\$535	\$267.50
Maine	\$260	\$75		\$335	\$167.50
Maryland	\$260	\$320		\$580	\$290.00
Massachusetts	\$260	\$150		\$410	\$205.00
Michigan	\$260	\$165	\$0 - \$25	\$425 - \$450	\$212.50 - \$225.00
Minnesota	\$260	\$250	\$15	\$510 - \$525	\$255.00 - \$262.50
Mississippi	\$260	\$225		\$485	\$242.50
Missouri	\$260	\$125	\$0 - \$40	\$385 - \$425	\$192.50 - \$212.50
Montana	\$260	\$100		\$360	\$180.00
Nebraska	\$260	\$75		\$335	\$167.50
Nevada	\$260	\$150		\$410	\$205.00
New Hampshire	\$260	\$100		\$360	\$180.00
New Jersey	\$260	\$295	\$0 - \$10	\$555 - \$565	\$277.50 - \$282.50
New Mexico	\$260	\$220		\$480	\$240.00
New York	\$260	\$240	\$0 - \$50	\$500 - \$550	\$250.00 - \$275.00
North Carolina	\$260	\$310		\$570	\$285.00
North Dakota	\$260	\$100		\$360	\$180.00
Ohio	\$260	\$295	\$0 - \$20	\$555 - \$575	\$277.50 - \$287.50
Oklahoma	\$260	\$235	\$0 - \$75	\$495 - \$570	\$247.50 - \$285.00
Oregon	\$260	\$50		\$310	\$155.00
Pennsylvania	\$260	\$255		\$515	\$257.50
Puerto Rico	\$260	\$0		\$260	\$130.00
Rhode Island	\$260	\$100		\$360	\$180.00
South Carolina	\$260	\$230		\$490	\$245.00
South Dakota	\$260	\$125		\$385	\$192.50
Tennessee	\$260	\$325		\$585	\$292.50
Texas	\$260	\$225	\$0 - \$130	\$485 - \$615	\$242.50 - \$307.50
Utah	\$260	\$100		\$360	\$180.00
Vermont	\$260	\$30		\$290	\$145.00
Virgin Islands	\$260	\$10		\$270	\$135.00
Virginia	\$260	\$225	\$0 - \$30	\$485 - \$515	\$242.50 - \$257.50
Washington	\$260	\$310	\$0 - \$75	\$570 - \$645	\$285.00 - \$322.50
West Virginia	\$260	\$275		\$535	\$267.50
Wisconsin	\$260	\$275	\$0 - \$20	\$535 - \$555	\$267.50 - \$277.50
Wyoming	\$260	\$25		\$285	\$142.50
Uniformed Services	\$260	\$50		\$310	\$155.50

**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!**