



supporting membership (other specialty) application

FOR OFFICE USE ONLY

OTHER

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

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

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 (_____) _____

EMAIL _____

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	\$170		\$440	\$220
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	\$235		\$505	\$252.50
Kansas	\$270	\$50		\$320	\$160
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	\$75		\$345	\$172.50
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	\$50		\$320	\$160
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	\$260	\$0 - \$75	\$530 - \$605	\$265 - \$302.50
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 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!**