AAFP
STRONG MEDICINE FOR AMERICA

active membership application

FOR OFFICE USE ONLY

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

Important: If you have held AAFP Active 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.

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?

PERSONAL INFORMATION

NAME (FIRST) _____

(MIDDLE) _____

(LAST) _____ (SUFFIX) _____

PREVIOUS LAST NAME (IF APPLICABLE)_____

DEGREE (MD/DO/MBBS/MBChB, ETC)_____

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

☐ MALE ☐ FEMALE ☐ TRANSGENDER ☐ OTHER ☐ PREFER NOT TO ANSWER

BUSINESS

☐ PLEASE INDICATE WITH A CHECK MARK IF THIS IS YOUR PREFERRED MAILING ADDRESS FOR RECEIVING INFORMATION AND SUBSCRIPTIONS FROM THE AAFP.

PRACTICE/BUSINESS NAME

_____

STREET ADDRESS

_____

_____

CITY _____

STATE _____ ZIP _____ COUNTRY _____

BUSINESS PHONE (_____)_____

FAX (_____)_____

EMPLOYER/PARENT ORGANIZATION

EMPLOYER/PARENT ORGANIZATION NAME

_____

STREET ADDRESS

_____

_____

CITY _____

STATE _____ ZIP _____ COUNTRY _____

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 _____ COUNTRY _____

HOME PHONE (_____)_____

PHONE NUMBER(S)

PLEASE INDICATE WITH A CHECK MARK YOUR PREFERRED PHONE NUMBER.

☐ BUSINESS (_____)_____

☐ HOME (_____)_____

☐ CELL (_____)_____

EMAIL ADDRESS

EMAIL_____

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

TWITTER HANDLE

TWITTER @_____

EDUCATION

MEDICAL SCHOOL

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE_____

COUNTRY_____

DEGREE_____

START DATE _____
(MM/DD/YYYY)

GRADUATION DATE_____
(MM/DD/YYYY)

AAFP
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EDUCATION CONTINUED

FAMILY MEDICINE RESIDENCY PROGRAM

NAME _____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE _____

COUNTRY _____

START DATE _____
(MM/DD/YYYY)

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)

OTHER TRAINING (IF APPLICABLE)

NAME _____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE _____

COUNTRY _____

EMPHASIS _____

COMPLETION DATE _____
(MM/DD/YYYY)

PROFESSIONAL INFORMATION

LICENSURE

MEDICAL LICENSE # _____

STATE _____ COUNTRY _____

ISSUANCE DATE _____ EXPIRATION DATE _____
(MM/DD/YYYY) *(MM/DD/YYYY)*

IF YOU DO NOT HAVE A CURRENT ACTIVE MEDICAL LICENSE WHERE YOU PRACTICE, PLEASE EXPLAIN (ATTACH A SEPARATE PAGE IF NECESSARY TO FULLY EXPLAIN)

_____

_____

_____

_____

_____

ARE YOU CURRENTLY CERTIFIED BY THE AMERICAN BOARD OF FAMILY MEDICINE (ABFM) THROUGH A RECIPROCITY AGREEMENT BETWEEN THE ABFM AND A FOREIGN COLLEGE OF FAMILY MEDICINE OR GENERAL PRACTICE? ☐ YES ☐ NO

ARE YOU ACTIVE DUTY MILITARY? ☐ 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, email 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, email, telephone, or fax.

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, 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 MEMBER RESOURCE 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 # _____

EXPIRATION DATE _____
(MM/YYYY)

SECURITY CODE/CVV# _____

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
aafp.org

2018 AAFP Active Dues Information

CHAPTER	AAFP	CHAPTER	LOCAL	TOTAL		Dues Total if After July 1
Alabama	$445	$295		$740		$370
Alaska	$445	$350		$795		$397.50
Arizona	$445	$325		$770		$385
Arkansas	$445	$250		$695		$347.50
California	$445	$300	$0 – $60	$745 – $805		$372.50 – $402.50
Colorado	$445	$415		$860		$430
Connecticut	$445	$325		$770		$385
Delaware	$445	$155		$600		$300
District of Columbia	$445	$215		$660		$330
Florida	$445	$350		$795		$397.50
Georgia	$445	$365		$810		$405
Guam	$445	$25		$470		$235
Hawaii	$445	$160		$605		$302.50
Idaho	$445	$295		$740		$370
Illinois	$445	$390		$835		$417.50
Indiana	$445	$365		$815		$407.50
Iowa	$445	$350		$795		$397.50
Kansas	$445	$320		$765		$382.50
Kentucky	$445	$350	$0 – $30	$795 – $825		$397.50 – $412.50
Louisiana	$445	$320		$765		$382.50
Maine	$445	$180		$625		$312.50
Maryland	$445	$395		$840		$420
Massachusetts	$445	$295		$740		$370
Michigan	$445	$375	$0 – $25	$820 – $845		$410 – $422.50
Minnesota	$445	$325	$0 – $15	$770 – $785		$385 – $392.50
Mississippi	$445	$300		$745		$372.50
Missouri	$445	$275	$0 – $100	$720 – $820		$360 – $410
Montana	$445	$195		$640		$320
Nebraska	$445	$325		$770		$385
Nevada	$445	$200		$645		$322.50
New Hampshire	$445	$145		$590		$295
New Jersey	$445	$295	$0 – $10	$740 – $750		$370 – $375
New Mexico	$445	$290		$735		$367.50
New York	$445	$290	$0 – $50	$735 – $785		$367.50 – $392.50
North Carolina	$445	$340		$785		$392.50
North Dakota	$445	$250		$695		$347.50
Ohio	$445	$399	$0 – $20	$844 – $864		$422 – $432
Oklahoma	$445	$275		$720		$360
Oregon	$445	$285		$730		$365
Pennsylvania	$445	$350		$795		$397.50
Puerto Rico	$445	$75		$520		$260
Rhode Island	$445	$265		$710		$355
South Carolina	$445	$295		$740		$370
South Dakota	$445	$215		$660		$330
Tennessee	$445	$335		$780		$390
Texas	$445	$350	$0 – $130	$795 – $925		$397.50 – $462.50
Utah	$445	$250		$695		$347.50
Vermont	$445	$125		$570		$285
Virgin Islands	$445	$10		$455		$227.50
Virginia	$445	$295	$0 – $25	$740 – $765		$370 – $382.50
Washington	$445	$310	$0 – $75	$755 – $830		$377.50 – $415
West Virginia	$445	$275		$720		$360
Wisconsin	$445	$318		$763		$381.50
Wyoming	$445	$125		$570		$285
Uniformed Services	$445	$295		$740		$370

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.

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Apply today for the membership that supports you and your profession.

Visit www.aafp.org/memapp to apply online.

MBR17101748