



# active membership application

FOR OFFICE USE ONLY

You can also apply for membership online at [www.aafp.org/memapp](http://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 \_\_\_\_\_ @ \_\_\_\_\_

## TEXT MESSAGE OPT-IN

I AGREE TO RECEIVE TEXT MESSAGE ALERTS ON A LIMITED BASIS FROM THE AAFP—UP TO ONE MESSAGE PER MONTH—REGARDING MY MEMBERSHIP STATUS, DUES, OR OTHER TIME-SENSITIVE NOTIFICATIONS.

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

## EDUCATION

### MEDICAL SCHOOL

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

CITY \_\_\_\_\_

STATE \_\_\_\_\_

COUNTRY \_\_\_\_\_

DEGREE \_\_\_\_\_

START DATE \_\_\_\_\_  
(MM/DD/YYYY)

GRADUATION DATE \_\_\_\_\_  
(MM/DD/YYYY)



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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 chapters 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**

# 2021 AAFP Active Dues Information

CHAPTER	AAFP	CHAPTER	LOCAL	TOTAL
Alabama	\$450	\$295		\$745
Alaska	\$450	\$350		\$800
Arizona	\$450	\$325		\$775
Arkansas	\$450	\$275		\$725
California	\$450	\$324	\$0-\$60	\$774-\$834
Colorado	\$450	\$425		\$875
Connecticut	\$450	\$350		\$800
Delaware	\$450	\$155		\$605
DC	\$450	\$225		\$675
Florida	\$450	\$350		\$800
Georgia	\$450	\$365		\$815
Guam	\$450	\$10		\$460
Hawaii	\$450	\$160		\$610
Idaho	\$450	\$295		\$745
Illinois	\$450	\$390		\$840
Indiana	\$450	\$365		\$815
Iowa	\$450	\$350		\$800
Kansas	\$450	\$340		\$790
Kentucky	\$450	\$380	\$0-\$30	\$830-\$860
Louisiana	\$450	\$320		\$770
Maine	\$450	\$210		\$660
Maryland	\$450	\$395		\$845
Massachusetts	\$450	\$305		\$755
Michigan	\$450	\$395	\$0-\$25	\$845-\$870
Minnesota	\$450	\$325	\$0-\$15	\$775-\$790
Mississippi	\$450	\$300		\$750
Missouri	\$450	\$300	\$0-\$100	\$750-\$850
Montana	\$450	\$235		\$685
Nebraska	\$450	\$325		\$775
Nevada	\$450	\$200		\$650
New Hampshire	\$450	\$145		\$595
New Jersey	\$450	\$295	\$0-\$10	\$745-\$755
New Mexico	\$450	\$310		\$760
New York	\$450	\$290	\$0-\$50	\$740-\$790
North Carolina	\$450	\$350		\$800
North Dakota	\$450	\$300		\$750
Ohio	\$450	\$399	\$0-\$25	\$849-\$874
Oklahoma	\$450	\$295		\$745
Oregon	\$450	\$285		\$735
Pennsylvania	\$450	\$375		\$825
Puerto Rico	\$450	\$75		\$525
Rhode Island	\$450	\$265		\$715
South Carolina	\$450	\$295		\$745
South Dakota	\$450	\$250		\$700
Tennessee	\$450	\$335		\$785
Texas	\$450	\$350	\$0-\$130	\$800-\$930
Uniformed Services	\$450	\$295		\$745
Utah	\$450	\$275		\$725
Vermont	\$450	\$150		\$600
Virgin Islands	\$450	\$10		\$460
Virginia	\$450	\$295	\$0-\$25	\$745-\$770
Washington	\$450	\$385	\$0-\$75	\$835-\$910
West Virginia	\$450	\$375		\$825
Wisconsin	\$450	\$334		\$784
Wyoming	\$450	\$125		\$575

**NOTE:** Dues will be prorated based on the month your membership is activated. 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.



11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680

**Apply today for the  
membership that  
supports you and  
your profession!**

**Visit [www.aafp.org/memapp](http://www.aafp.org/memapp) to apply online.**