



# resident membership application

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

ARE YOU A PREVIOUS MEMBER OF THE AAFP?  YES  NO IF YES, PREVIOUS AAFP ID (IF KNOWN)? \_\_\_\_\_

## PERSONAL INFORMATION

NAME (FIRST) \_\_\_\_\_  
(MIDDLE) \_\_\_\_\_  
(LAST) \_\_\_\_\_ (SUFFIX) \_\_\_\_\_  
DEGREE (MD/DO/MBBS/MBChB, ETC) \_\_\_\_\_  
PREVIOUS LAST NAME (IF APPLICABLE) \_\_\_\_\_  
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.  
OFFICE/PRACTICE/INSTITUTION NAME \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
BUSINESS PHONE (\_\_\_\_\_) \_\_\_\_\_

## 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 \_\_\_\_\_  
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 @ \_\_\_\_\_

## MEDICAL SCHOOL EDUCATION

NAME \_\_\_\_\_  
(PLEASE DO NOT ABBREVIATE)  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_  
DEGREE \_\_\_\_\_  
START DATE (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YYYY) \_\_\_\_\_  
GRADUATION DATE (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YYYY) \_\_\_\_\_

## FAMILY MEDICINE RESIDENCY PROGRAM

NAME \_\_\_\_\_  
(PLEASE DO NOT ABBREVIATE)  
CITY \_\_\_\_\_ STATE \_\_\_\_\_  
RESIDENCY START DATE (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YYYY) \_\_\_\_\_  
RESIDENCY COMPLETION DATE (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YYYY) \_\_\_\_\_

## POST-RESIDENCY FELLOWSHIP (IF APPLICABLE)

NAME \_\_\_\_\_  
(PLEASE DO NOT ABBREVIATE)  
CITY \_\_\_\_\_ STATE \_\_\_\_\_  
EMPHASIS \_\_\_\_\_  
FELLOWSHIP COMPLETION DATE (MM) \_\_\_\_\_ (DD) \_\_\_\_\_ (YYYY) \_\_\_\_\_

## PROFESSIONAL

MEDICAL LICENSE NO. \_\_\_\_\_  
STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_  
ISSUANCE DATE \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

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 ACTIVE MILITARY?  YES  NO

## LONGITUDINAL STUDY

THE AAFP IS COLLECTING HIGH SCHOOL CITY, STATE, AND COUNTRY DATA TO BE UTILIZED FOR A LONGITUDINAL STUDY CONCERNING PHYSICIAN WORKFORCE.  
HIGH SCHOOL CITY \_\_\_\_\_ STATE \_\_\_\_\_  
COUNTRY \_\_\_\_\_

## 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 \_\_\_\_\_

(Additional information on back)

# 2018-2019 AAFP Resident Dues Information

**DO NOT SEND MONEY WITH YOUR APPLICATION.**

Upon approval of your membership, you will receive an invoice.

If you have any questions, please contact the AAFP at (800) 274-2237.

CHAPTER	AAFP	CHAPTER	TOTAL
Alabama	\$30	\$20	\$50
Alaska	\$30	\$0	\$30
Arizona	\$30	\$0	\$30
Arkansas	\$30	\$65	\$95
California	\$30	\$10	\$40
Colorado	\$30	\$10	\$40
Connecticut	\$30	\$15	\$45
Delaware	\$30	\$0	\$30
District of Columbia	\$30	\$0	\$30
Florida	\$30	\$10	\$40
Georgia	\$30	\$25	\$55
Hawaii	\$30	\$0	\$30
Idaho	\$30	\$0	\$30
Illinois	\$30	\$15	\$45
Indiana	\$30	\$20	\$50
Iowa	\$30	\$10	\$40
Kansas	\$30	\$0	\$30
Kentucky	\$30	\$0	\$30
Louisiana	\$30	\$15	\$45
Maine	\$30	\$0	\$30
Maryland	\$30	\$20	\$50
Massachusetts	\$30	\$0	\$30
Michigan	\$30	\$25	\$55
Minnesota	\$30	\$10	\$40
Mississippi	\$30	\$0	\$30
Missouri	\$30	\$10	\$40
Montana	\$30	\$0	\$30

CHAPTER	AAFP	CHAPTER	TOTAL
Nebraska	\$30	\$5	\$35
Nevada	\$30	\$0	\$30
New Hampshire	\$30	\$0	\$30
New Jersey	\$30	\$10	\$40
New Mexico	\$30	\$0	\$30
New York	\$30	\$25	\$55
North Carolina	\$30	\$35	\$65
North Dakota	\$30	\$0	\$30
Ohio	\$30	\$0	\$30
Oklahoma	\$30	\$25	\$55
Oregon	\$30	\$10	\$40
Pennsylvania	\$30	\$0	\$30
Puerto Rico	\$30	\$0	\$30
Rhode Island	\$30	\$0	\$30
South Carolina	\$30	\$0	\$30
South Dakota	\$30	\$0	\$30
Tennessee	\$30	\$12.50	\$42.50
Texas	\$30	\$10	\$40
Utah	\$30	\$20	\$50
Vermont	\$30	\$0	\$30
Virginia	\$30	\$25	\$55
Washington	\$30	\$0	\$30
West Virginia	\$30	\$0	\$30
Wisconsin	\$30	\$0	\$30
Wyoming	\$30	\$0	\$30
Uniformed Services	\$30	\$0	\$30

**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.

**PLEASE SEND YOUR COMPLETED APPLICATION TO:**



**AAFP**

**American Academy of Family Physicians**  
**11400 Tomahawk Creek Parkway**  
**Leawood, KS 66211-2680**  
**Phone: (800) 274-2237**  
**Fax: (913) 906-6075**  
**[aafp.org](http://aafp.org)**