AAFP
STRONG MEDICINE FOR AMERICA

resident membership application

You can also apply for membership online at 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)

2017-2018
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	$20	$50
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 to learn what portion of your AAFP national and chapter dues are not deductible.

PLEASE SEND YOUR COMPLETED APPLICATION TO:

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