AAFP
STRONG MEDICINE FOR AMERICA

resident membership application

FOR OFFICE USE ONLY

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

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

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

PERSONAL INFORMATION

NAME (FIRST) _____

(MIDDLE) _____

(LAST) _____ (SUFFIX) _____

TITLE (MD/DO/PHD,ETC) _____

PREVIOUS NAME (IF APPLICABLE) _____

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

☐ MALE ☐ FEMALE

IF YOU ARE ACTIVE MILITARY, PLEASE LET US KNOW YOUR BRANCH OF SERVICE. _____

EMAIL_____
(YOU **MUST** PROVIDE A WORKING EMAIL ADDRESS IN ORDER TO RECEIVE CERTAIN MEMBER BENEFITS.)

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 _____

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 _____

HOME PHONE (_____)_____

CELL PHONE (_____)_____

MEDICAL SCHOOL EDUCATION

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) _____

POST-RESIDENCY FELLOWSHIP/ADDITIONAL TRAINING (IF APPLICABLE)

NAME_____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE_____

ADDITIONAL QUALIFICATIONS/CERTIFICATIONS _____

FELLOWSHIP COMPLETION DATE (MM) _____ (DD) _____ (YYYY) _____

PROFESSIONAL

LICENSE NO. _____

STATE_____

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)

_____

_____

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** _____

(Additional information on back)

2012-2013
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 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	$5	$35
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	$0	$30
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	$15	$45
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
www.aafp.org

FOR OFFICE USE ONLY

DATE STAMP

INITIALS