



supporting membership application

FOR OFFICE USE ONLY

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

SUPPORTING MEMBERS SHALL BE:

1. Physicians residing and practicing in the United States (or its territories or possessions) who completed an ACGME- or AOA-accredited residency program in specialties other than family medicine and not otherwise eligible for some other category of membership; or
2. Physicians who previously held supporting membership before September 30, 2016.

ARE YOU A PREVIOUS MEMBER OF THE AAFP? YES NO

IF YES, PREVIOUS AAFP MEMBER ID (IF KNOWN) _____

PERSONAL INFORMATION

FIRST NAME _____

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 _____ COUNTY _____

BUSINESS PHONE (_____) _____

BUSINESS 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 _____ COUNTY _____

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)



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EDUCATION CONTINUED

RESIDENCY PROGRAM

NAME _____
(PLEASE DO NOT ABBREVIATE)

CITY _____

STATE _____

SPECIALTY _____

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 ACTIVE 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/CV# _____

CARD HOLDER'S NAME _____

CARD HOLDER'S SIGNATURE _____

PLEASE SEND COMPLETED APPLICATION AND PAYMENT 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 Supporting Dues Information

CHAPTER	AAFP	CHAPTER	LOCAL	TOTAL	Dues Total if After July 1
Alabama	\$290	\$275		\$565	\$282.50
Alaska	\$290	\$250		\$540	\$270
Arizona	\$290	\$325		\$615	\$307.50
Arkansas	\$290	\$250		\$540	\$270
California	\$290	\$265	\$0 - \$60	\$555 - \$615	\$277.50 - \$307.50
Colorado	\$290	\$220		\$510	\$255
Connecticut	\$290	\$325		\$615	\$307.50
Delaware	\$290	\$155		\$445	\$222.50
District of Columbia	\$290	\$210		\$500	\$250
Florida	\$290	\$200		\$490	\$245
Georgia	\$290	\$325		\$615	\$307.50
Guam	\$290	\$10		\$300	\$150
Hawaii	\$290	\$160		\$450	\$225
Idaho	\$290	\$295		\$585	\$292.50
Illinois	\$290	\$305		\$595	\$297.50
Indiana	\$290	\$365		\$655	\$327.50
Iowa	\$290	\$235		\$525	\$262.50
Kansas	\$290	\$320		\$610	\$305
Kentucky	\$290	\$350	\$0 - \$30	\$640 - \$670	\$320 - \$335
Louisiana	\$290	\$320		\$610	\$305
Maine	\$290	\$115		\$405	\$202.50
Maryland	\$290	\$395		\$685	\$342.50
Massachusetts	\$290	\$295		\$585	\$292.50
Michigan	\$290	\$260	\$0 - \$25	\$550 - \$575	\$275 - \$287.50
Minnesota	\$290	\$250	\$0 - \$15	\$540 - \$555	\$270 - \$277.50
Mississippi	\$290	\$300		\$590	\$295
Missouri	\$290	\$125	\$0 - \$100	\$415 - \$515	\$207.50 - \$257.50
Montana	\$290	\$100		\$390	\$195
Nebraska	\$290	\$180		\$470	\$235
Nevada	\$290	\$150		\$440	\$220
New Hampshire	\$290	\$100		\$390	\$195
New Jersey	\$290	\$295	\$0 - \$10	\$585 - \$595	\$292.50 - \$297.50
New Mexico	\$290	\$290		\$580	\$290
New York	\$290	\$270	\$0 - \$50	\$560 - \$610	\$280 - \$305
North Carolina	\$290	\$330		\$620	\$310
North Dakota	\$290	\$125		\$415	\$207.50
Ohio	\$290	\$399	\$0 - \$20	\$689 - \$709	\$344.50 - \$354.50
Oklahoma	\$290	\$275		\$565	\$282.50
Oregon	\$290	\$285		\$575	\$287.50
Pennsylvania	\$290	\$255		\$545	\$272.50
Puerto Rico	\$290	\$0		\$290	\$245
Rhode Island	\$290	\$150		\$440	\$220
South Carolina	\$290	\$295		\$585	\$292.50
South Dakota	\$290	\$125		\$415	\$207.50
Tennessee	\$290	\$335		\$625	\$312.50
Texas	\$290	\$225	\$0 - \$130	\$515 - \$645	\$257.50 - \$322.50
Utah	\$290	\$100		\$390	\$195
Vermont	\$290	\$30		\$320	\$160
Virgin Islands	\$290	\$10		\$300	\$150
Virginia	\$290	\$225	\$0 - \$25	\$515 - \$540	\$257.50 - \$270
Washington	\$290	\$310	\$0 - \$75	\$600 - \$675	\$300 - \$337.50
West Virginia	\$290	\$275		\$565	\$282.50
Wisconsin	\$290	\$318		\$608	\$304
Wyoming	\$290	\$25		\$315	\$157.50
Uniformed Services	\$290	\$50		\$340	\$170

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.



AAFP

STRONG MEDICINE FOR AMERICA

11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680

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