AMERICAN ASSOCIATION FOR PHYSICIAN LEADERSHIP®

Application for Public Health Membership

American Association for PHYSICIAN LEADERSHIP®
Inspiring Change. Together.

Physicians eligible for membership in the association: MD and DO physicians who have graduated from a medical school, in the U.S. or Canada, accredited by the Liaison Committee on Medical Education (LCME), or have graduated from an osteopathic college of medicine accredited by the American Osteopathic Association (AOA), and who are members of the U.S. Public Health Service Commissioned Corps serving Native Americans, PHS/HIS, public health/free clinic and FQHC Clinic populations. **Annual dues are $225**. No examination is required for membership. Please return this completed application along with payment of $225 (U.S. currency) to the address below.

Please type or print clearly or attach your primary business card.

■ Name _____
FIRST NAME MIDDLE (OPTIONAL) LAST NAME

❒ MD ❒ DO ❒ MBBS ❒ Other Degrees _____ Date of Birth: _____ Nickname _____

PRIMARY POSITION AND ORGANIZATION INFORMATION — *REQUIRED

Job Title _____

I have held this position since_____ . I devote approximately _____% of my professional time to this position.

*Medical School _____ Year Graduated _____

Organization_____

Organization Address _____

City/State/Zip/Country_____

❒ Please send all correspondence to the above address.

❒ Preferred mailing address_____
City/State/Zip/Country _____

*Phone _____ Fax _____ *Primary E-mail Address _____

TO BETTER SERVE OUR MEMBERS, WE ASK YOU FOR THE FOLLOWING INFORMATION

Gender: ❒ Male ❒ Female

Race or ethnicity: ❒ African-American ❒ American Indian/Alaskan Native ❒ Asian/Pacific Islander ❒ Caucasian ❒ Hispanic
❒ Other _____

Primary Specialty _____ Board Certified? ❒ Yes ❒ No

Reason for joining _____

Referred by_____

CODE OF CONDUCT

In signing this application, I certify that I meet the requirements for the American Association for Physician Leadership® Membership as stated above and that I have read and agree to the association's Code of Conduct (www.physicianleaders.org/conduct) and that the information contained herein is correct. I understand that misrepresentation or omission of facts is cause for my application to be rejected or future dismissal.

Signature of Applicant _____ Date _____

PAYMENT

Charge $225 to my credit card: ❒ Visa ❒ MasterCard ❒ Discover ❒ American Express

Credit Card # _____ Exp. Date_____

Signature on credit card _____ Date _____

❒ Check enclosed (payable to American Association for Physician Leadership®)

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