



MEMBERSHIP APPLICATION

In order for a DPM to join AAPPMPM, he/she must be a member in good standing of the American Podiatric Medical Association. Office staff must have a DPM in their practice who is an APMA and AAPPMPM member.

APMA Member Number

APPLICANT INFORMATION

Name Year Began in Practice (if DPM)

Practice or DPM Name (if assistant)

Address

City State Zip

Phone Email

TYPE OF PRACTICE

Solo Practitioner All Podiatrist Group Hospital Based Multi-Disciplined Group

Do you work in an: Orthopedic Practice Larger Medical Practice that provides services other than podiatry

Are you the owner of your own practice? Yes No

MEMBERSHIP TYPE & FEES (Membership fees are subject to change without notice. Current membership fees can be found at www.aappmpm.org.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Active APMA Member \$369 | <input type="checkbox"/> Resident APMA Member FREE
<small>(compliments of corporate education sponsors)</small> | <input type="checkbox"/> Executive Manager \$139
<small>(non DPM staff member)</small> |
| <input type="checkbox"/> Senior APMA Member \$169 | <input type="checkbox"/> Student APMA Member FREE | <input type="checkbox"/> Assistant/Staff Member \$139 |
| <input type="checkbox"/> Associate (4yrs or less) APMA Member \$169 | | |

PAYMENT OPTIONS

Check payable to AAPPMPM enclosed VISA MasterCard AMEX

Card Number Exp Date

Name on Card CVV

Billing Address (if different)

City State Zip

REQUIRED AUTHORIZATION

Information given on this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition of making this application, any misrepresentations, mis-statements, or omissions, whether intentional or not, shall constitute cause for rejection of this application and/or membership. I authorize the American Academy of Podiatric Practice Management to contact me via fax and email.

Signature Date