



active membership application

FOR OFFICE USE ONLY

YES, I want to become an Active Member of the American Academy of Family Physicians. I support the AAFP's mission of advocating for the specialty of family medicine.

NAME IN FULL (AND PREVIOUS, IF APPLICABLE) _____

DATE OF APPLICATION _____ DATE OF BIRTH _____ MALE FEMALE

OFFICE ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PREFERRED MAILING ADDRESS: OFFICE HOME COUNTY _____

OFFICE PHONE _____ HOME PHONE _____

FAX _____ E-MAIL _____

EDUCATION:	INSTITUTION/PROGRAM	CITY/STATE/COUNTRY	DEGREE	GRADUATION DATE/LEVEL OF TRAINING
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MEDICAL _____

FAMILY MEDICINE RESIDENCY PROGRAM _____

FELLOWSHIP _____

LICENSE NO. _____ STATE _____ ISSUE DATE _____ EXP. DATE _____

ARE YOU CURRENTLY CERTIFIED BY THE AMERICAN BOARD OF FAMILY MEDICINE (ABFM) THROUGH A RECIPROCITY AGREEMENT BETWEEN THE ABFM AND A FOREIGN COLLEGE OF FAMILY MEDICINE OR GENERAL PRACTICE? YES NO

ARE YOU NOW ENGAGED IN FAMILY MEDICINE? YES NO DATE YOU ENTERED FAMILY MEDICINE _____

CURRENT PRACTICE ACTIVITIES: SOLO PRACTICE GROUP PRACTICE TEACHING RESEARCH ADMINISTRATIVE

MILITARY BRANCH _____ GOV'T/NON-MILITARY OTHER _____

NAME AND ADDRESS OF GROUP OR INSTITUTION (IF APPLICABLE) _____

IF YOU HAVE PREVIOUSLY HELD AAFP MEMBERSHIP, PLEASE INDICATE TYPE, DATE AND CHAPTER AFFILIATION:

STUDENT RESIDENT ACTIVE SUPPORTING INACTIVE

DATE OF PREVIOUS MEMBERSHIP _____ CHAPTER AFFILIATION _____

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 _____

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 any money submitted will be refunded if my application is not approved. 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 _____

If applicant has never been an Active or Supporting FP member, or has not held Active or Supporting FP membership within the past two years, CME credits are not required. If the applicant has been an Active or Supporting FP member within the past two years, he/she must provide evidence of 100 CME credits completed during that time. Please submit CME records to AAFP, Attn: Contact Center, 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680. You can also fax your CME records to Attn: Contact Center, (913) 906-6088.

(Additional information on back)

2009 AAFP Dues Chart

CHAPTER	AAFP	CHAPTER	TOTAL
Alabama	\$350.00	\$275.00	\$625.00
Alaska	\$350.00	\$275.00	\$625.00
Arizona	\$350.00	\$295.00	\$645.00
Arkansas	\$350.00	\$225.00	\$575.00
California	\$350.00	\$265.00	\$615.00
Colorado	\$350.00	\$325.00	\$675.00
Connecticut	\$350.00	\$250.00	\$600.00
Delaware	\$350.00	\$125.00	\$475.00
District of Columbia	\$350.00	\$210.00	\$560.00
Florida	\$350.00	\$300.00	\$650.00
Georgia	\$350.00	\$365.00	\$715.00
Guam	\$350.00	\$ 10.00	\$360.00
Hawaii	\$350.00	\$160.00	\$510.00
Idaho	\$350.00	\$200.00	\$550.00
Illinois	\$350.00	\$390.00	\$740.00
Indiana	\$350.00	\$317.00	\$667.00
Iowa	\$350.00	\$313.50	\$663.50
Kansas	\$350.00	\$275.00	\$625.00
Kentucky	\$350.00	\$350.00	\$700.00
Louisiana	\$350.00	\$225.00	\$575.00
Maine	\$350.00	\$150.00	\$500.00
Maryland	\$350.00	\$295.00	\$645.00
Massachusetts	\$350.00	\$225.00	\$575.00
Michigan	\$350.00	\$300.00	\$650.00
Minnesota	\$350.00	\$270.00	\$620.00
Mississippi	\$350.00	\$225.00	\$575.00
Missouri	\$350.00	\$275.00	\$625.00
Montana	\$350.00	\$125.00	\$475.00

CHAPTER	AAFP	CHAPTER	TOTAL
Nebraska	\$350.00	\$250.00	\$600.00
Nevada	\$350.00	\$190.00	\$540.00
New Hampshire	\$350.00	\$110.00	\$460.00
New Jersey	\$350.00	\$295.00	\$645.00
New Mexico	\$350.00	\$210.00	\$560.00
New York	\$350.00	\$260.00	\$610.00
North Carolina	\$350.00	\$310.00	\$660.00
North Dakota	\$350.00	\$150.00	\$500.00
Ohio	\$350.00	\$295.00	\$645.00
Oklahoma	\$350.00	\$235.00	\$585.00
Oregon	\$350.00	\$235.00	\$585.00
Pennsylvania	\$350.00	\$330.00	\$680.00
Puerto Rico	\$350.00	\$75.00	\$425.00
Rhode Island	\$350.00	\$195.00	\$545.00
South Carolina	\$350.00	\$230.00	\$580.00
South Dakota	\$350.00	\$200.00	\$550.00
Tennessee	\$350.00	\$325.00	\$675.00
Texas	\$350.00	\$350.00	\$700.00
Utah	\$350.00	\$225.00	\$575.00
Vermont	\$350.00	\$100.00	\$450.00
Virgin Islands	\$350.00	\$10.00	\$360.00
Virginia	\$350.00	\$225.00	\$575.00
Washington	\$350.00	\$310.00	\$660.00
West Virginia	\$350.00	\$275.00	\$625.00
Wisconsin	\$350.00	\$275.00	\$625.00
Wyoming	\$350.00	\$125.00	\$475.00
Uniformed Services	\$350.00	\$275.00	\$625.00

Additional local dues may apply.
Call the AAFP Contact Center at (800) 274-2237 for more information.

DO NOT SEND MONEY WITH APPLICATION.

Upon approval of your membership, you will receive an invoice.
If you have any questions, please contact the AAFP Contact Center at (800) 274-2237.

PLEASE SEND YOUR COMPLETED APPLICATION TO:



AAFP American Academy of Family Physicians
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
Phone: (800) 274-2237
Fax: (913) 906-6280
www.aafp.org

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CHAPTER ACTION: APPROVED APPROVAL NOT RECOMMENDED FOR APPLICANT

REMARKS: _____

SIGNATURE _____ DATE _____
(Constituent Chapter Officer)

SIGNATURE _____ DATE _____
(Local/Component Chapter Officer)