2019 Membership Application

Web

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), or graduated from a recognized international equivalent school. **Dues are for a 12 month period renewed on an anniversary date.**

Join on line at physicianleaders.org /join **or** complete this form and email to kdresser@physicianleaders.org ● (fax)813 287 8993

Home Details—*All mailed items will go to this address:

First Name:_____ Middle:_____Lastname:_____Nickname:_____

Home Address:_____ City:_____ St/Terr:_____ Zip/Postal:_____ Country:_____

Home Phone:_____ Mobile Phone:_____ Personal Email:_____

Work Details—*AAPL Directory Listing: ☐ I work in a private practice ☐ I work for an Organization ☐ I work as a contractor

Practice/Org Name:_____ Job Title:_____ No. of physicians:_____

Work Address:_____ City:_____ St/Terr:_____ Zip/Postal:_____ Country:_____

Work Phone:_____ Work Email:_____ Work Web Address:_____

To better service you as our individual member, we ask for the following information please.

Medical School Name:_____ State:_____ Graduation Year:_____ MD ☐ DO ☐ MBBS ☐

State/s Licensed In:_____ Primary Specialty:_____ Board Certified ☐ • Secondary Specialty:_____

Optional: Gender:_____ Date of Birth:_____ Race/Ethnicity:_____

Referred by: Dr/Mr/Ms _____ ☐ Web Search ☐ Mailing ☐ AAPL Booth ☐ AAPL Event ☐ _____

AAPL Business Conduct and Ethics Code: 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 Business Conduct and Ethics Code (physicianleaders.org/membership/business-conduct-and-ethics-code) 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:_____

Complete this form and mail to Kim Dresser with your check. Do not put credit card number in mail, you can scan application to kdresser@physicianleaders.org and call Kim (813)636 2806 to supply payment via credit card.

☐ Yes, charge my card $_____ USD for AAPL Membership. Or submit check payable to AAPL.
Card Number:_____ Expiration Month and Year:_____ Security Code:_____

Types of Membership (please check one only):

☐ **Physician- $295**
Private practice, organization or contractor

☐ **Military or Public Health Organization- $195**

☐ **Medical Student/ Resident/Fellow- $50**

☐ **Rising Leader- $150**
Within 5 years practicing physician experience

☐ **International- $225**
Outside of the US

☐ **Affiliate- $295**
Healthcare provider not MD or DO