

# Application for U.S. Military Membership

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 are active in any branch of the U.S. military. **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](http://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®)