AADM MEMBERSHIP APPLICATION

(Membership Year January 1 - December 31)

Section I: Personal Data (All Information Must be Typed or Printed)

Name: ______________________ Degrees: ______________________

Preferred Address for Correspondence (check one) Home __________ Office __________

Home Address: ____

City: __________________ State: __________ Zip: ______________

Office Address: ____

City: __________________ State: __________ Zip: ______________

Home Number: ______________________ Cell Number: ______________________

Office Number: ______________________ E-Mail Address: ______________________

Office Fax: ______________________ Pager: ______________________

Spouse's Full Name: __________________ Would you like information about the Auxiliary? _______ Yes/No

Social Security Number: ______________ Birth Date: __________ Gender: __________

Are you in a solo practice or group practice? (check one) Solo __________ Group __________

Primary License: ____
Number State Exp. Date

Other License(s): ____
Number State Exp. Date

Is your current medical license(s) restricted? Yes _____ No _____
(If yes, please provide details on separate sheet and attach to application.)

Has your license(s) ever been suspended or revoked? Yes _____ No _____
(If yes, please provide details on separate sheet and attach to application.)

Medical School: ____ Graduation Date: _______________

Section II: Medical

Please list national, state, or regional medical associations, hospitals and managed care organizations of which you are a member and specify if you have or are serving in a leadership position:

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Section III: Required Documentation

_____ Completed Application (printed or typed)

_____ Notary Signature and Seal on Back of Application

_____ Copy of Medical Degree

_____ Copy of All Active State Medical Licenses (must include expiration date)

_____ Foreign Graduates Include ECFMG and English Translation or Medical Degree

_____ Fees: $695.00 make payable to AADM/ABPS

Send membership application, annual fee and documents to:

American Academy of Disaster Medicine
5550 West Executive Drive, Suite 400
Tampa, FL 33609
(813) 433-2277

____ having appeared before me and being properly identified as the same individual who has signed this application, duly sworn, deposes and states that:

- [x] under penalty, he/she is the person named on this application for membership in the American Academy of Disaster Medicine;
- [x] all statements made on this application and all documents accompanying this application are true and factual;
- [x] the applicant understands and agrees that any false statement contained in the application shall invalidate, from its inception, his/her affiliation with the American Academy of Disaster Medicine;
- [x] the applicant releases any medical institution, education institution, licensing agency, and/or individual to give information needed by the American Academy of Disaster Medicine in connection with this application.

____
(Signature of Applicant)

Subscribed and sworn before me this __________ day of __________, ___/___/___

____
Notary Signature and Seal Required

____
Address of Notary