



# AAPS 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: \_\_\_\_\_

Office Number: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Home Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_ 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: \_\_\_\_\_

Seeking AAPS Board Certification in the following specialty: \_\_\_\_\_

**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: Membership**

Please indicate membership category for which you are applying. After the application has been approved, a dues invoice will be sent to you.

- \_\_\_\_\_ Regular Member
- \_\_\_\_\_ Military Regular Member
- \_\_\_\_\_ Resident Member

**Section IV: 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

**Send membership application and documents to:**

American Association of Physician Specialists, Inc.  
5550 West Executive Drive Suite 400  
Tampa, FL. 33609

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

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

(Signature of Applicant)

\_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Notary Signature and Seal Required

\_\_\_\_\_  
Address of Notary