AMERICAN ASSOCIATION OF PHYSICIAN SPECIALISTS, INC.

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:

_____

_____

_____

Over

5550 West Executive Drive • Suite 400 • Tampa, Florida 33609
Tel: 813-433 AAPS (2277) • Fax 813-830-6599 • www.aapsus.org

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