# APPLICATION FOR CHANGE IN MEMBERSHIP STATUS TO RETIRED MEMBERSHIP

Please print the following information:

Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Please attest to the following statement by signing and providing the date in the designated area at the bottom of this form.

**I request that my membership status be changed, effective _____, to Retired Member. I attest that I will be completely retired as a physician as of _____ with no active practice hours in any month during the dues year. I am currently in good standing and in compliance with all requirements for membership in the American Association of Physician Specialties, Inc. In order to qualify for retired membership in ensuing years, I understand that each year I must provide to the Membership Officer a written statement that I am not engaged in the practice of medicine and have no expectation of actively practicing medicine during the dues year.**

Official Date of Retirement from Medical Practice: _____

Signature of Physician: _____

Date _____

**Please return by mail or fax:**
Fax: 813-830-6599

AAPS Membership Office,
5550 West Executive Dr, Suite 400
Tampa, FL 33609

Rev. 6/09