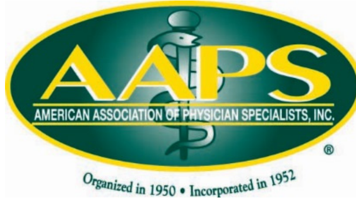

AAPS MEMBERSHIP APPLICATION

(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:

____

____

____

Over

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

Send membership application and documents to:

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

After the application has been approved, a dues invoice will be sent to you.

____ 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

10/17