AAPS MEMBERSHIP APPLICATION

(Membership Year January 1 - December 31)

Please Note: This is NOT an application for ABPS specialty board certification. For information regarding applying for board certification, visit the ABPS website at www.abpsus.org.

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

Name: _____ Degrees: _____

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

E-Mail Address: _____

Cellular Phone: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Office Number: _____ Office Fax: _____

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

Last 4 Digits of Social Security Number: _____ Birth Date: _____ Gender: _____

Medical Specialty: _____ NPI or CAMD (Canada) Number: _____

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: _____

Over

Section II: Memberships/Leadership Positions

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:

_____

_____

_____

Section III: Required Documentation

_____ Completed Application (printed or typed)

_____ 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

Section IV: Signature

By signing below, you agree to the following:

- I certify that I am the person named on this application for membership in the American Association of Physician Specialists, Inc.;
- I understand that this is NOT an application for specialty board certification;
- All statements I have made on this application and all documents accompanying this application are true and factual;
- I understand and agree that any false statement contained in the application shall invalidate, from its inception, my affiliation with the American Association of Physician Specialists, Inc.;
- I release 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.
- I understand that, if my application is approved, I will be required to remit membership dues on an annual basis in order to maintain active membership status, qualify for member benefits, and participate in AAPS activities.

Signature: _____ Date: _____

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.