Membership Types: O Fellow ($50.00) O Associate ($20.00 Contact APAC for Approval) O Student ($10.00)

Contact Information:

Full Name: ____

Mailing Address: ____

City/State/Zip: ____

Home Phone: __________________________ **Cell Phone:** _______________________

Email: ____

Employer: ____

Other Information:

AAPA Member? O Yes O No AAPA#: ____________________________

NCCPA Certified? O Yes O No NCCPA#: ___________________________

My Specialty/Area of Interest: ____

Work Setting (please circle one): Inpatient Outpatient Both

Supervising Physician Name: ____

May we contact you with CME, Employment and Product information? O Yes O No

May we list you in any membership listings or directory? O Yes O No

May we contact you for help in committees and APAC projects? O Yes O No

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