

Application

Join AAHPM online at www.aahpm.org, or mail this completed application to AAHPM, 4700 W. Lake Ave., Glenview, IL, 60025.

Name _____ Credentials _____

Title _____ Preferred mailing address Office Home

Institution _____

Street address _____

City/State/ZIP _____

Home address _____

City/State/ZIP _____

Telephone: Home _____ Work _____

Fax _____ E-mail _____

Type of Membership

Physician **\$395**

Practicing physician who holds an MD, DO, or equivalent degree and is actively engaged in the field of palliative care and hospice medicine

Affiliate **\$195**

Nurse, social worker, pharmacist or other nonphysician healthcare professional

Fellow **\$125**

Fellow who is currently in a fellowship program with an accredited institution; documentation must be provided from the current fellowship program director

Resident **\$20**

Resident with documentation from the dean of the program; this is a virtual membership (electronic access only)

Student **\$20**

Full-time medical or nursing student with documentation from the dean of the program; this is a virtual membership (electronic access only)

International Corresponding **Free**

Physician at the post-graduate level who reside in a nation included on the HINARI list of eligible countries with supporting documentation; cannot vote, hold office, or serve on AAHPM committees or task forces; this is a virtual membership (electronic access only)

Primary Board Specialty (Select one)

- | | |
|---|---|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Emergency Medicine |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Internal Medicine |
| <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Physical Medicine and Rehabilitation | |
| <input type="checkbox"/> Psychiatry/Neurology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Other _____ |

Subspecialty _____

Primary Setting (Select one)

- | | |
|--|---|
| <input type="checkbox"/> Clinical Private Practice | <input type="checkbox"/> Community Hospital |
| <input type="checkbox"/> For-Profit Hospice | <input type="checkbox"/> Nonprofit Hospice |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Government (VA, NIH, etc.) |
| <input type="checkbox"/> Nursing Home Facility | <input type="checkbox"/> University Health Center |
| <input type="checkbox"/> Other | |

Professional Discipline (Select one)

- | | | |
|-----------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Ministry | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Social Work | <input type="checkbox"/> Other |

Payment

Mastercard **Visa** **American Express** **Discover**

Check enclosed (payable to AAHPM; must be in US funds. A \$25 charge will apply to checks returned for insufficient funds.)

Account number _____ Expiration date _____

Signature _____ Cardholder's name (please print) _____

Consult your tax adviser for information on dues deductibility.