

Application

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

Name _____ Professional credentials _____
Title _____ Preferred mailing address Office Home
Institution _____
Street address _____
City/State/ZIP _____
Home address _____
City/State/ZIP _____
Telephone: Home _____ Work _____
E-mail _____ Fax _____

Type of Membership

Application Fee (Required for new members) **\$25**

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, physician assistant, 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 resides in a developing country as defined by the World Health Organization (Band 1 or 2); this is a virtual membership (electronic access only)

Primary Board Specialty (Select one)

- Anesthesiology Emergency Medicine
 Family Medicine Internal Medicine
 Obstetrics/Gynecology Pediatrics
 Physical Medicine and Rehabilitation
 Psychiatry/Neurology Radiology
 Surgery Other _____

Subspecialty _____

Primary Setting (Select one)

- Clinical Private Practice Community Hospital
 For-Profit Hospice Nonprofit Hospice
 Home Health Agency Government (VA, NIH, etc.) Nursing Home Facility
 University Health Center Other _____

Professional Discipline (Select one)

- Physician Chaplain Nurse
 Pharmacist Social Worker Other
 Physician Assistant

Visit aahpm.org to complete your member profile.

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.