AMERICAN PODIATRIC MEDICAL ASSOCIATION

Application for Membership

I hereby apply for membership in the component association of the state in which I have my principal practice and to the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, constitution and bylaws, code of ethics, and all rules and regulations of my component association and the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

Please Type or Print.
Attach additional sheet of paper if needed.

Last Name ______________________ First ________________ Middle ________

Previous Last Name (Changed due to marriage, divorce, etc.)______________________

Birth Date _____ / _____ / ______ Nickname ______________________

Social Security No. (Optional): ________________ Sex: ❑ M ❑ F

Ethnic Group (for demographic use only): ❑ White ❑ Black ❑ Hispanic ❑ American Indian ❑ Asian/Pacific

Spouse's Name__________________________ US Citizen (Optional): ❑ Yes ❑ No

Practice Name ______________________________________

Your Status in the Practice: ❑ Owner ❑ Employee

Complete all addresses below.

Please note your preferred iling address by placing a eck mark in the box to the left of that address.

❑ **Home Address:** ______________________________________

____

Telephone ( ) ______________________ Fax ( ) ________________

Home e-mail: ______________________

❑ **Principal Office/Residency Address:** ______________________________

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Telephone ( ) ______________________ Fax ( ) ________________

Office e-mail: ____________________ Office Web Site: ________________

❑ **Second Office Address:** ______________________________________

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Telephone ( ) ______________________ Fax ( ) ________________

Office e-mail: ____________________ Office Web Site: ________________

❑ **Third Office Address:** ______________________________________

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Telephone ( ) ______________________ Fax ( ) ________________

Office e-mail: ____________________ Office Web Site: ________________

If you have more than three office addresses, please list on a separate sheet.

Education

Undergraduate Degree

❏ Yes If yes, complete ❏ No

Year ______ State _______ Institution __________________________________ Degree ________

Graduate Degree

❏ Yes If yes, complete ❏ No

Year ______ State _______ Institution __________________________________ Degree ________

Podiatric Medical Degree

Check College Below Year of Graduation __________

❏ Barry ❏ California ❏ Iowa ❏ New York ❏ Ohio ❏ Temple ❏ Scholl ❏ Other________

Postgraduate Education

If you have more than two residencies, please list on a separate sheet.

❏ Yes If yes, complete ❏ No

❏ Preceptorship
❏ Residency (check one only):
❏ Rotating Podiatric Residency (RPR) ❏ Podiatric Orthopedic Residency (POR)
❏ Primary Podiatric Medical Residency (PPMR) ❏ Primary Surgical Residency (PSR)

Begin Date ________ (mo / yr) State _____ Institution _______________________ Completion Date ________ (mo / yr)

❏ Preceptorship
❏ Residency (check one only):
❏ Rotating Podiatric Residency (RPR) ❏ Podiatric Orthopedic Residency (POR)
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Begin Date ________ (mo / yr) State _____ Institution _______________________ Completion Date ________ (mo / yr)

Military

Military Service

❏ USA ❏ USAF ❏ USN ❏ USMC ❏ USCG Other ______________________________

Date Entered ________________ Date Separated ______________ Current Rank ______________

❏ Reserves If yes, branch of service ____

Professional Licensure

Podiatric Medical Licenses

Year _____ State _____ Number _____________________

Year _____ State _____ Number _____________________

Year _____ State _____ Number _____________________

Have you ever had a license to practice podiatric medicine suspended or revoked in any state?

❏ Yes ❏ No If yes, please explain on a separate sheet.

Are you currently, or have you ever been, on probation, suspension, or investigation by any licensure authority, state or federal agency?

❏ Yes ❏ No If yes, please explain on a separate sheet.

Professional Medical Practice

Original Practice Start Date

Month ______ Day ______ Year _______

APMA-Recognized Organizations

(check only those in which you have certification/membership)

Board Certification

(see back panel for listings)

❏ ABPS ❏ ABPOPPM-PO ❏ ABPOPPM-PPM ❏ ABPOPPM-PMO ❏ Other ____________________

Affiliated/Related Membership

(see back panel for listings)

❏ AAHHP ❏ AAPPM ❏ AAPSM ❏ AAWP ❏ ACFAOM ❏ ACFAP ❏ ACFAS ❏ ACPMR

❏ ACPR ❏ APCS ❏ APMWA ❏ ASPD ❏ ASPM ❏ CMMT ❏ Other ____________________

Previous Member of APMA

❏ Yes If yes, complete ❏ No

Dates ______________ Component Association ____

Signature/Instructions

Please submit a sample of your stationery, business card and a copy of all state licenses with this application.

I understand that dual membership (state component and national association) is required to be a member in good standing. I agree not to represent myself as a member of APMA or my component, if for any reason, I cease to be a member in good standing. I also understand that a portion of my annual dues is in payment for a one year subscription for the *APMA NEWS* and for the *Journal of the American Podiatric Medical Association*. I agree that incomplete or false information may be grounds for denial or termination of membership.

APMA dues are not deductible as a charitable contribution for federal tax purposes but may be deductible as a business expense.

***Unless you are in a residency program, please forward your completed application and dues payment directly to your component.* Applications for resident membership should be sent directly to APMA, along with your dues payment.**

Requested timing of dues payments to APMA (check one):

❏ Quarterly ❏ Semi-Annually ❏ Annually

Applicant Signature: ____________________________________ , DPM Date: _______________

I was recruited for APMA membership by the following APMA member: ________________________

Listing of Boards

ABPOPPM-PO	American Board of Podiatric Orthopedics and Primary Podiatric Medicine (Podiatric Orthopedics Certificate)
ABPOPPM-PPM	American Board of Podiatric Orthopedics and Primary Podiatric Medicine (Primary Podiatric Medicine Certificate)
ABPOPPM-PMO	American Board of Podiatric Orthopedics and Primary Podiatric Medicine (Podiatric Medicine and Orthopedics Certificate)
ABPS	American Board of Podiatric Surgery

Listing of Affiliated/Related Associations

AAHHP	American Association of Hospital and Healthcare Podiatrists
AAPPM	American Academy of Podiatric Practice Management
AAPSM	American Academy of Podiatric Sports Medicine
AAWP	American Association of Women Podiatrists
ACFAOM	American College of Foot and Ankle Orthopedics and Medicine
ACFAP	American College of Foot and Ankle Pediatrics
ACFAS	American College of Foot and Ankle Surgeons
ACPMR	American College of Podiatric Medical Review
ACPR	American College of Podiatric Radiologists
APCS	American Podiatric Circulatory Society
APMWA	American Podiatric Medical Writers Association
ASPD	American Society of Podiatric Dermatology
ASPM	American Society of Podiatric Medicine
CMMT	Conference on Multi Cultural Membership and Talents

For Component Society Use

Component name:___________________________________

Division (If applicable):______________________________

Date application was received:________________________

Date sent to APMA:__________________________________

Join date:____

Member category:___________________________________

For APMA Use Only

Dues Amount _______________

Member No. _______________

Member Type _______________

Date Received _______________

Elect Date _______________