



Membership Application

Please complete information. Please enclose copies of your AAPA, or affiliated AAPA constituent organization card, NCCPA and/or Illinois Registration membership card along with your check for dues and return to address below.

Fellow, \$150.00

Fellow membership in this organization shall be restricted to persons who are classified as fellow members of the American Academy of Physician Assistants. Fellow members shall have full voting rights and shall be eligible to hold office.

Affiliate, \$125.00

Affiliate membership shall consist of individuals who desire to associate with the Academy, and who are eligible for, but do not desire AAPA fellow membership, such as pharmaceutical representatives and suppliers, and who are approved by the Board of Directors. Affiliates shall be entitled to privileges of the floor, but shall not be entitled to vote or hold office.

Sustaining, \$125.00

A sustaining member is a PA who meets the requirements for fellow membership but is not actively practicing as a PA or is practicing in another state. They receive membership benefits but do not vote or hold office.

Associate, \$60.00

A certified physician assistant eligible for Fellow membership who has designated another constituent organization as his/her representative in the AAPA House of Delegates. They have the privilege of the floor but may not vote or hold office. Designated Constituent Name: _____

Physician, \$125.00

A physician member is a physician licensed in Illinois. They will have privileges of the floor only.

Student, \$20.00 for a two-year membership

Student members shall be individuals enrolled in a physician assistant training program approved by the Board of Directors. These students shall be entitled to the privileges of the floor, but shall not be entitled to vote or hold office.

Pre-PA Student, \$10.00 for a one-year membership

Prospective student members shall be individuals who plan to enroll in a physician assistant training program approved by the Board of Directors. These students shall be entitled to the privileges of the floor, but shall not be entitled to vote or hold office.

NCCPA#: _____ AAPA#: _____ IL License#: _____

First Name: _____ MI: ____ Last Name: _____

Home Address: _____

Home City: _____ Home State: _____ Home Zip: _____

Home Telephone: _____ Home Fax: _____

Home County: _____ Home Email: _____

Office Name: _____

Office Address: _____

Office City: _____ Office State: _____ Office Zip: _____

Office Telephone: _____ Office Fax: _____

Office County: _____ Office Email: _____

Practice Location: *(please check one)* _____ Rural _____ Urban _____ HPSA
(over)

DEMOGRAPHICS: Male: _____ Female: _____ Year of Birth: _____

PA School Attended: _____ Year Graduated: _____

Clinical Practice: Are you currently a clinically practicing physician assistant? ___ Yes ___ No

If yes: Full time or Part time

Primary Supervising Physician: _____

If no: Other _____

Setting: *(check one):*

____ Solo Office Practice _____ Hospital/Public _____ Inner city/Clinic/Hospital
____ Group Office Practice _____ Clinic/Public _____ Military/Clinic/Hospital
____ Jail/Prison _____ Clinic/Private _____ Other Clinical
____ HMO _____ Nursing Home _____ Other: Non-Clinical
____ Hospital/Private _____ Rural Clinic/Hospital

Specialty: *(Place a #1 in your primary specialty and #2 in your secondary specialty.)*

____ Anesthesiology _____ Other _____ Allergy
____ Anesthesiology _____ Neurology _____ Public H/PrefEd
____ Dermatology _____ BO/Gin _____ Radiology
____ Emergency Medicine _____ Ophthalmology _____ General Surgery
____ Family/General Practice _____ Orthopedics ***Surgical Subspecialties***
____ Geriatrics _____ Otolaryngology _____ Cardiovascular
____ Gen. Int. Medicine _____ Pathology _____ Colon and Rectal
Internal Medical Subspecialties _____ General Pediatrics _____ Hand
____ Cardiovascular Disease ***Pediatric Subspecialties*** _____ Neurological
____ Critical Care _____ Allergy _____ Pediatric
____ Endocrinology _____ Cardiology _____ Plastic
____ Gastroenterology _____ Endocrinology _____ Thoracic
____ Hematology/Immunology _____ Hematology/Oncology _____ Traumatic
____ Infectious Disease _____ Nephrology _____ Urological
____ Nephrology _____ Neurology _____ Vascular
____ Pulmonary _____ Pulmonary Other: _____
____ Rheumatology _____ Physical Medicine/Rehab Other: _____

Malpractice Coverage:

____ No Malpractice Insurance
____ Individual Policy with AAPA
____ Rider on Employer's Policy
____ Rider on Employer's Policy with IL State Medical Inter-Insurance Exchange
____ Employer self insures
____ Other: _____

Professional Public Relations:

____ I am interested in being a practice site for a PA Program.
____ I am interested in a mentor with a PA Student or PA Program.
____ I am interested in an instructor role with a PA Program.
____ I am willing to serve as a phone contact for PA students.
____ I am interested in being a phone contact for PAs looking for employment.
____ Please exclude my name from the annual directory.

I am interested in the following IAPA Committees:

____ CME _____ Membership _____ Legislative _____ Public Education

(IAPA now accepts credit cards for dues and for CME meetings.)

I authorize the 'Association Management Partners' to charge my credit card for my IAPA dues in the amount of \$ _____

VISA _____ MC _____ AmExp _____ Other _____

Credit Card Number & Name : _____

Exp. Date: _____ Signature: _____

My IAPA-PAC Contribution is \$ _____. IAPA-PAC's (Political Action Committee) commission is to foster an awareness of the Physician Assistant with candidates running for state office. A copy of our report will be filed with the State Board of Elections and will be available for purchase from the State Board of Elections, Springfield, IL 62706.

Association dues are not deductible as charitable contributions for federal income tax purposes

Send completed application with check made payable to IAPA, 225 East Cook Street, Springfield, IL 62704