apma
Advancing foot and ankle medicine and surgery

American Podiatric Medical Association

www.apma.org • membership_ask_apma@apma.org
1-800-ASK-APMA

Other Professional Member

As a licensed MD, DO, or other appropriately credentialed professional, I hereby apply for membership in the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulations of the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

Please type or print clearly.

Attach additional sheet of paper if needed.

Birth date, gender, and ethnic group are requested for statistical purposes.

First Name _____ Middle _____

Last _____ Designation ❍ MD ❍ DO ❍ Other _____

Previous Last Name *(changed due to marriage, divorce, etc.)* _____

Birth Date _____ / _____ / _____ Nickname _____

Gender: ❍ M ❍ F Ethnic Group *(for demographic use only)*: ❍ American Indian/Alaska Native ❍ Asian* ❍ Black or African American ❍ Native Hawaiian or Other Pacific Island ❍ Spanish/Hispanic/Latino/Latina** ❍ White ❍ Do not wish to report

* This category includes Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, Malaysian, Pakistani, or Vietnamese
** This category includes Cuban, Mexican, Mexican American, Chicano/Chicana, Puerto Rican, South, or Central American

US Citizen *(optional)*: ❍ Yes ❍ No

Complete all addresses below.

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

*Your home address is essential for identifying and contacting your federal and state legislators through APMA's e-Advocacy program.

**Please include your e-mail address as APMA communicates many important issues via e-mail.

❑ **Home Address*:** _____

_____

Telephone ( ) _____ Fax ( ) _____

Cell ( ) _____ Pager ( ) _____

Home e-mail**: _____

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

_____

Telephone ( ) _____ Fax ( ) _____

Office e-mail**: _____

Office Web Site: _____

❑ **Second Office Address:** _____

_____

Telephone ( ) _____ Fax ( ) _____

Office e-mail**: _____

Office Web Site: _____

❑ **Third Office Address:** _____

_____

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

Year _____ State _____ Institution _____ Degree _____

Graduate Degree

Year _____ State _____ Institution _____ Degree _____

Medical/Osteopathic Degree

Medical/Osteopathic College _____

Year _____ Degree ❍ MD ❍ DO

Other Credentials Institution_____ Certification_____Year _____

Postgraduate Education

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

❍ Yes *(If yes, complete)* ❍ No

❍ Fellowship ❍ Residency

Program Name_____ State_____

Begin Date_____ State_____ Institution_____ Completion Date_____
mo / yr mo / yr

_____

❍ Yes *(If yes, complete)* ❍ No

❍ Fellowship ❍ Residency

Program Name_____ State_____

Begin Date_____ State_____ Institution_____ Completion Date_____
mo / yr 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

National Provider Identifier (NPI) Number

_____

Medical/ Osteopathic Licenses

Year_____ State_____ Number_____ Year_____ State_____ Number_____

Year_____ State_____ Number_____ Year_____ State_____ Number_____

Year_____ State_____ Number_____ Year_____ State_____ Number_____

Has your license to practice medicine or osteopathic medicine been suspended or revoked?

❍ Yes (*If yes, please explain on a separate sheet.)* ❍ No

Are you currently on probation or under investigation by any licensure authority, state, or federal agency?

❍ Yes (*If yes, please explain on a separate sheet.)* ❍ No

Agreement

By signing below I agree to the following:

- If elected to membership, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulation of the APMA.
- I agree not to represent myself as a member of APMA, if for any reason, I cease to be a member in good standing.
- I agree that incomplete or false information may be grounds for denial or suspension of membership.

Applicant Signature:_____ Date:_____

Forward your completed application, copies of all professional degrees, diplomas, and/or certificates to:

American Podiatric Medical Association
11400 Rockville Pike Ste 220
Rockville, MD 20852

If your professional degrees, diplomas, and/or certificates are written in a language other than English, a written English translation must be provided.

Applications received without copies of all professional degrees, diplomas, and/or certificates, written English translation (if needed), AND dues payment cannot be processed.

The fiscal year of APMA runs from June 1st to May 31st. Dues for MDs, DOs, and other appropriately credentialed professionals, are $232.00 per year. Based on actions of the APMA House of Delegates, this amount is subject to change. Pro-rating of dues is available for membership activated after the beginning of the fiscal year.

An APMA representative will contact you for collection of dues.