FLORIDA ACADEMY OF PHYSICIAN ASSISTANTS MEMBERSHIP APPLICATION

□ New
□ Renewal

Membership dues year runs from January 1st through January 1st.

Name (Last, First, Middle Initial)		
Home Address		
City/State/Zip		
Home Phone	Home Fax	County of Residence
Email Address		
Name of Supervising Physician ☐ M.D. ☐ D.O.		Specialty
Business Address		
City/State/Zip		
Business Phone	Business Fax	SPONSOR

MEMBERSHIP CATEGORIES:

I am joining as (please check ONE)

	Category	Dues			Category	Dues
	Fellow	$185			Physician	$100
	Associate	$185			Military	$50
	Affiliate	$185			Retired	$50
	Corporate	See Corp. Application			Friendship	$50
	Honorary	Complimentary			Student	$50 / 2 years

Preferred Mailing Address: **(If no choice is selected, all information will be published in the FAPA Membership Directory.)**

☐ **Business** ☐ **Home** ☐ DO NOT publish **any** information in Directory ☐ OK to publish **all** information in Directory

☐ DO NOT publish **home phone** in Directory

PA School Attended:					
NCCPA Certified		No		Yes	Certification Number:
AAPA Member		No		Yes	Membership Number:
Florida License		No		Yes	License Number:
Florida Prescribing Privileges		No		Yes	Prescriber Number:

Please fill in the blanks below and write the Total Amount enclosed:

FAPA Dues (see Membership Categories above)	$
Voluntary Contribution to FAPA Foundation Student Scholarship Fund	$
Donation: FAPA Foundation (FAPAF is a non-profit 501(c)(3) corporation and donations are tax deductible.)	$
Total Amount Enclosed	**$**

In accordance with Section 6033(e)(2)(A) of the Internal Revenue Code, as amended, members of the Florida Academy of Physician Assistants (FAPA) are hereby notified that an estimated 5% of your FAPA dues will be allocated to lobbying and political activities, and therefore are not deductible as a business expense.)

☐ I do not want 10% of my dues delegated to the Physician Assistant Political Action Committee (PA-PAC).
(FAPA has established a Political Action Committee, the PA- PAC, for the purpose of supporting political candidates who have befriended the PA profession. 10% of yearly dues will automatically be designated for PA-PAC unless otherwise indicated. This contribution is not tax deductible.)

Payment is by:
□ Check # _________ for $ _____ payable to FAPA

☐ **VISA** ☐ **MasterCard** ☐ **American Express**

I authorize FAPA to charge the amount of $___________ to my credit card as checked above.
Card # ___________________________ Exp. Date ____________
3 or 4 Digit Security Code ______________________________
Print Cardholder Name: ________________________________
Authorized Signature: _________________________________

Return Form and Payment to:

F.A.P.A.
222 S. Westmonte Drive, #101
Altamonte Springs, FL 32714
Phone (407) 774-7880 * Fax (407) 774-6440

FOR FAPA OFFICE USE ONLY
Proc _________ **Ref #**_________ **Amount** __________ **Date** _________ **Comp** _________

Revised: 10-2009