



FLORIDA ACADEMY OF PHYSICIAN ASSISTANTS MEMBERSHIP APPLICATION

New
 Renewal

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

Name (Last, First, Middle Initial)		Designation(s)	
PA School Attended/Attending		Graduation Date or Expected Graduation Date:	
Home Address			
City/State/Zip			
Home Phone	Home Fax	County of Residence	
Email Address			
Name of Supervising Physician <input type="checkbox"/> M.D. <input type="checkbox"/> D.O.		Specialty	
Business Address			
City/State/Zip		County of Business	
Business Phone	Business Fax	SPONSOR	

MEMBERSHIP CATEGORIES:

I am joining as (please check ONE)

<input type="checkbox"/> Fellow	\$185*	<input type="checkbox"/> Physician	\$100
<input type="checkbox"/> Associate	\$185*	<input type="checkbox"/> Military	\$50
<input type="checkbox"/> Affiliate	\$185*	<input type="checkbox"/> Retired	\$50
<input type="checkbox"/> Corporate	See Corp. Application	<input type="checkbox"/> Friendship	\$50
<input type="checkbox"/> Honorary	Complimentary	<input type="checkbox"/> Student	\$50 / 2 years

***QUARTERLY PRO-RATED DUES INFORMATION - ONLY FOR NEW - or - FORMER FELLOW, ASSOCIATE OR AFFILIATE Members (those former members who have NOT renewed their FAPA Membership for three years or more) is as follows:**
 If you join between: First Quarter: JAN-MAR = \$185; Second Quarter: APR - JUN = \$138.75; Third Quarter: JUL-SEPT = \$92.50;
 Fourth Quarter: OCT-DEC = \$185 - member receives the balance of the current dues year and all of the following dues year.

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

Business **Home** OK to publish **all** information in Directory Yes No **DO NOT** publish **home phone** in Directory

NCCPA Certified	<input type="checkbox"/> No <input type="checkbox"/> Yes	Certification Number:
AAPA Member	<input type="checkbox"/> No <input type="checkbox"/> Yes	Membership Number:
Florida License	<input type="checkbox"/> No <input type="checkbox"/> Yes	License Number:
Florida Prescribing Privileges	<input type="checkbox"/> No <input type="checkbox"/> Yes	Prescriber Number:

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

FAPA Dues (see Membership Categories above)	\$	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.) <input type="checkbox"/> 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.)
Voluntary Contribution to FAPA Foundation Student Scholarship Fund	\$	
Donation: FAPA Foundation <small>(FAPAF is a non-profit 501(c)(3) corporation and donations are tax deductible.)</small>	\$	
Total Amount Enclosed	\$	

Payment is by:

Check # _____ for \$ _____ payable to FAPA

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

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

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: _____

FOR FAPA OFFICE USE ONLY

Proc _____	Ref # _____	Amount _____	Date _____	Comp _____
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