



AAPM&R Membership Application

Advanced Practice Provider (PA or NP)

First Name (PLEASE PRINT)

M. I.

Last Name

Degree(s)

BUSINESS ADDRESS*

Preferred Mailing

Preferred Billing

HOME ADDRESS

Preferred Mailing

Preferred Billing

Title

Street/Apt

Institution

Department/Room/Suite

City, State, Zip

Street

Country

City, State, Zip

Telephone

Mobile Phone

Country

Fax

Telephone

Home Email Address

Primary Email

Fax

Business Email Address

Primary Email

Website URL

* Your business address will be used for the Member Directory. *The Physiatrist* will be sent to your preferred mailing address, and dues renewal notices to your preferred billing address. All Academy email communications will be sent to your primary email address.

PERSONAL AND PROFESSIONAL INFORMATION

Date of Birth (MM/DD/YY)

Gender: Male Female Non-Binary

Do you consider yourself to be a gender or sexual minority? Yes No

Do you consent to allow AAPM&R to store and process your ethnicity information? Yes No

The Academy is committed to the principle of diversity in its membership and leadership. Accordingly, applicants are invited to indicate which one of the following may best describe them (check all that apply):

Black or African American (Africa, West Indian, Caribbean) Asian (Far East, Southeast Asia, Indian)

American Indian or Alaska Native (North America, South America, Central America) White (Europe, Middle East, North Africa)

Hispanic (of any race) Native Hawaiian or Other Pacific Islander (Hawaii, Guam, Samoa, Pacific Islands)

Do you consider yourself to have a disability as defined by the Americans with Disabilities Act? Yes No

Primary Language Spoken

APPs: Accredited Training Program

Graduation

MONTH/YEAR

Licensed in the state of

Year

Number

NPI Number (if applicable)

Years in PM&R

NCCPA Certificate Number

AANP or ANCC Certificate Number

MM/YY

MM/YY

MEMBERSHIP ATTESTATION AND SPONSOR INFORMATION

INITIAL

I am applying to be an **ADVANCED PRACTICE PROVIDER IN THE ACADEMY**. I have acquired the education or licensure/certification, or formal appointment relevant and customary for a Physician Assistant or Nurse Practitioner.

INITIAL

I attest that I currently work on an integrated rehabilitation team with a physiatrist. **My membership is sponsored by the following Academy member:**

Name of Physiatrist Sponsor*:

*Sponsors must be a current Fellow, Part-Time Fellow, or Associate member of AAPM&R in good standing. The sponsoring member will be required to confirm that he/she works with the applicant on an integrated rehabilitation team.

MEMBER COMMUNITIES

MEMBER COMMUNITIES are self-identified, organically established communities offering opportunities for members of all different backgrounds to connect with each other, share experiences, collaborate, and advance the future of the specialty together!

Adaptive Athletes and Sports	International Rehabilitation and Global Health	Physiatry Life Care Planners
African American Physiatrists	Interventional Pain	Private Practice Physiatrists
Age-Friendly Care in Rehabilitation	Kosher Physiatry	Puerto Rican Physiatrists
Alternative Pain Medicine	LatinX in Physiatry	Regenerative Medicine
Amputee/Limb Loss Restoration	LGBTQIA+ in Physiatry	Research in Physiatry
Rehabilitation	Medical Student Education	Running Medicine
Asian Physiatrists	Muslim Physiatrists	Shockwave Therapy for Musculoskeletal and Neurological Conditions
Brain Injury Medicine Current Fellows and Future Candidates	Neuromodulation	South Asian Physiatrists
Business of Healthcare Physiatrists	Neuromuscular Medicine and EDX	Spasticity Management
Cancer Rehabilitation Medicine	Ohio Physiatrists	Spina Bifida Providers
Central Nervous System (CNS)	Overhead Athlete	Spinal Cord Injury Medicine
Chicago Physiatrists	Pain Medicine	Spine Medicine
Early-Career Physiatrists	Pediatric Inpatient Rehabilitation	Sports Medicine
Exercise as Medicine	Pediatric Rehabilitation Medicine	Sports Medicine Current Fellows and Future Candidates
Hypermobility Syndrome	Pediatric Rehabilitation Medicine Current Fellows/Combination Residents and Future Candidates	Therapeutic Cannabis Physiatrists
Innovation and Artificial Intelligence	Pediatric Sports Medicine	Value Based Spine Care
Inpatient Rehabilitation	Performing Arts Medicine	Women Physiatrists
Inpatient Rehabilitation	Physiatry in Skilled Nursing Facilities	Wound Medicine

HOW DID YOU HEAR ABOUT US?

Colleague AAPM&R Website AAPM&R Email Communications Mentor
Other (please specify)

SIGNATURE OF APPLICANT

If I am accepted for membership in the American Academy of Physical Medicine and Rehabilitation I agree to support its bylaws and to practice in accordance with the established principles of the American Medical Association.

Signature of Applicant

Date

If you are a resident of the European Union and/or United Kingdom, please review our privacy policy at <http://www.aapmr.org/privacy-policy/privacy-policy-eu-uk>

PAYMENT INFORMATION

MEMBER TYPE & FEES

Physician Assistant	\$250 (USD)
Nurse Practitioner	\$250 (USD)

FORM OF PAYMENT

Check # Made payable to AAPM&R

To pay by credit card, call AAPM&R
Customer Service at (847) 737-6000.

REMIT PAYMENT AND FORMS

MAIL TO: American Academy of Physical Medicine
and Rehabilitation
P.O. Box 95528
Chicago, IL 60694-5528

**Please do not send payments to the national office.*

FAX: Fax your membership application to (847) 563-4191
and then call AAPM&R's Customer Service team at
(847) 737-6000 from 8:30 am-5 pm (CT) to pay over
the phone with a credit card.

QUESTIONS? Email us at memberservices@aapmr.org.

THANK YOU!

Thank you for your interest in joining the American Academy of Physical Medicine and Rehabilitation (AAPM&R). For more information on member benefits and to learn more about the organization, please visit: www.aapmr.org.



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