



AAPM&R Membership Application

Associate (Completed Training in a PM&R Residency Program)

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		Referring Member (IF APPLICABLE)	
Business Email Address		*Your business address will be used for the Member Directory. The <i>PM&R</i> journal and <i>The Physiatrist</i> 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.	
Primary Email			
Website URL			

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

Academic Degrees	Conferred by	Date	MONTH/YEAR
Medical Degrees	Conferred by	Date	MONTH/YEAR
PM&R Residency: Institution		Graduation	MONTH/YEAR

Licensed in the state of Year Number

NPI Number Opioid Prescriber Number

MEMBERSHIP TYPE

I am applying for **ASSOCIATE MEMBERSHIP IN THE ACADEMY**. I have completed training in an approved PM&R residency program.

I have passed Part I of the ABPMR, dated _____, _____ (if applicable).

MONTH YEAR

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	Intellectual Disability	Performing Arts Medicine
African American Physiatrists	International Rehabilitation and Global Health	Physiatry in Skilled Nursing Facilities
Age-Friendly Care in Rehabilitation	Interventional Pain	Physiatry Life Care Planners
Alternative Pain Medicine	Introverted Leaders	Private Practice Physiatrists
Amputee/Limb Loss Restoration Rehabilitation	Kosher Physiatry	Puerto Rican Physiatrists
Asian Physiatrists	LatinX in Physiatry	Regenerative Medicine
Brain Injury Medicine Current Fellows and Future Candidates	LGBTQIA+ in Physiatry	Research in Physiatry
Business of Healthcare Physiatrists	Medical Educators	Running Medicine
Cancer Rehabilitation Medicine	Muslim Physiatrists	South Asian Physiatrists
Central Nervous System (CNS)	Neuromodulation	Spasticity Management
Chicago Physiatrists	Neuromuscular Medicine and EDX	Spine Medicine
Early-Career Physiatrists	Overhead Athlete	Sports Medicine
Exercise as Medicine	Pain Medicine	Sports Medicine Current Fellows and Future Candidates
Hypermobility Syndrome	Pediatric Rehabilitation Medicine	Texas Physiatrists
Inpatient Consultants	Pediatric Rehabilitation Medicine Current Fellows/Combination Residents and Future Candidates	Therapeutic Cannabis Physiatrists
Inpatient Rehabilitation	Pediatric Sports Medicine	Women Physiatrists
		Wound Medicine

HOW DID YOU HEAR ABOUT US?

Colleague AAPM&R Website Residency Director 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

Associate Member
2024 Calendar Year Membership \$750 (USD)

FORM OF PAYMENT

Check # Made payable to AAPM&R

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.

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

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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