AAPM&R Membership Application

Medical Students

INSTRUCTIONS: This application must be completed in its entirety to be processed.
(Please attach a copy of your transcript or student ID card for identification.)

Internal Use Only
Institute ID#

First Name (PLEASE PRINT) | M. I. | Last Name | Degree(s)

MEDICAL SCHOOL ADDRESS* ○ Preferred Mailing ○ Preferred Billing

Institution (School Name)
Street
City, State, Zip
Country
Telephone
Fax
Personal Medical School Email Address ○ Primary Email

HOME ADDRESS* ○ Preferred Mailing ○ Preferred Billing

Street/Apt
City, State, Zip
Country
Telephone ○ Mobile Phone
Fax
Home Email Address ○ Primary Email

* Your Home Address will be used by AAPM&R for all billing and correspondence, and your Medical School address will be used for the Member Directory. 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

EDUCATIONAL INFORMATION (REQUIRED FOR PROCESSING)

Expected completion date of medical school MONTH , YEAR .

Does your medical school have a PM&R Interest Group? ○ Yes ○ No

If yes, who is the main contact? NAME EMAIL PHONE

Expected medical degree: ○ MD ○ DO ○ Other .

Additional Graduate Education	Name of College or University	Degree	Graduation Date

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.

(Please attach a copy of your transcript or student ID card for identification.)

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

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PAYMENT INFORMATION

MEMBER TYPE & FEES

○ Medical Student FREE

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 TO: (847) 563-4191

QUESTIONS? Email us at memberservices@aapmr.org.

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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.

aapm&r
American Academy of
Physical Medicine and Rehabilitation

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www.aapmr.org

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