



AAPM&R Membership Application

Medical Students

Internal Use Only

Institute ID#

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.)

First Name (PLEASE PRINT)	M. I.	Last Name	Degree(s)	
MEDICAL SCHOOL ADDRESS*	Preferred Mailing	Preferred Billing	HOME ADDRESS*	Preferred Mailing Preferred Billing
Institution (School Name)			Street/Apt	
Street				
City, State, Zip			City, State, Zip	
Country			Country	
Telephone			Telephone	Mobile Phone
Fax			Fax	
Personal Medical School Email Address		Primary Email	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?

Expected medical degree: MD DO Other NAME EMAIL PHONE

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>

PAYMENT INFORMATION

MEMBER TYPE & FEES

Medical Student with journal \$40 (USD)
*Includes one-year print subscription to the *PM&R* Journal.

Medical Student without journal 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
Faxed applications must include CREDIT CARD
PAYMENT information.

QUESTIONS? Email us at memberservices@aapmr.org.

FORM OF PAYMENT (for optional subscription)

Check # Made payable to AAPM&R

Credit Card

MasterCard VISA Discover American Express

Expiration Date / CVV

Credit Card Number

Cardholder's Name (PLEASE PRINT NAME AS IT APPEARS ON CARD)

Signature (CREDIT CARD PAYMENTS ONLY)

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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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