AAPM&R Membership Application

Residents (U.S. and Canada)

Internal Use Only

Institute ID#

Program Pays

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

INSTITUTE ADDRESS* ○ Preferred Mailing ○ Preferred Billing

Residency Program

Resident Coordinator Name

Department/Room/Suite

Street

City, State, Zip

Country

Telephone

Fax

Business 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

Referring member (if applicable)

*The *PM&R* journal and *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

NPI Number

EDUCATIONAL INFORMATION (REQUIRED FOR PROCESSING)

Expected start date of residency training in PM&R , . (MONTH, YEAR)

Expected completion date of residency training in PM&R , . (MONTH, YEAR)

Graduate Education	Name of College or University	Degree	Graduation Date	From (MM/YY)	To (MM/YY)
Medical School	**Name of College or University**	**Degree**	**Graduation Date**	**From (MM/YY)**	**To (MM/YY)**
Internship/Clinical Affiliations	**Name of Institution or Location**		**Type of Service**	**From (MM/YY)**	**To (MM/YY)**

CONTINUED ON BACK »

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
- ☐ African American Physiatrists
- ☐ Alternative Pain Medicine
- ☐ Amputee/Limb Loss Restoration Rehabilitation
- ☐ Brain Injury Medicine Fellowship Directors
- ☐ Business of Healthcare Physiatrists
- ☐ Cancer Rehabilitation Medicine
- ☐ Central Nervous System (CNS)
- ☐ Chicago Physiatrists
- ☐ Early-Career Physiatrists
- ☐ Exercise as Medicine
- ☐ Geriatric Rehabilitation
- ☐ Inpatient Consultants
- ☐ Inpatient Rehabilitation
- ☐ Intellectual Disability
- ☐ Interventional Pain
- ☐ Introverted Leaders
- ☐ Kosher Physiatry
- ☐ LatinX in Physiatry
- ☐ Medical Educators
- ☐ Muslim Physiatrists
- ☐ Neuromodulation
- ☐ Neuromuscular Medicine and EDX
- ☐ Overhead Athlete
- ☐ Pain Medicine
- ☐ Pediatric Rehabilitation Medicine
- ☐ Pediatric Rehabilitation Medicine Current Fellows/Combination Residents and Future Candidates
- ☐ Pediatric Rehabilitation Medicine Fellowship Program Directors
- ☐ Pediatric Sports Medicine
- ☐ Performing Arts Medicine
- ☐ Physiatry in Skilled Nursing Facilities
- ☐ Physiatry Life Care Planners
- ☐ Private Practice Physiatrists
- ☐ Regenerative Medicine
- ☐ Research in Physiatry
- ☐ Running Medicine
- ☐ South Asian Physiatrists
- ☐ Spine Medicine
- ☐ Sports Medicine
- ☐ Sports Medicine Current Fellows and Future Candidates
- ☐ Texas Physiatrists
- ☐ 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

☐ Resident $75 (USD)
*Includes one-year subscription to the *PM&R* Journal.

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

☐ 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)

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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