



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	
HOME ADDRESS	Preferred Mailing	Preferred Billing	
Residency Program _____		Street/Apt _____	
Resident Coordinator Name _____		_____	
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 _____		Primary Email _____	

*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)

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