



# AAPM&R Membership Application

## Advanced Practice Provider (PA or NP)

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

\*Your business address will be used for the Member Directory. 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.

Business 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

APPs: Accredited Training Program

Graduation

MONTH/YEAR

Licensed in the state of

Year

Number

NPI Number (if applicable)

Years in PM&R

NCCPA Certificate Number

AANP or ANCC Certificate Number

MM/YY

MM/YY

## MEMBERSHIP ATTESTATION AND SPONSOR INFORMATION

I am applying to be an **ADVANCED PRACTICE PROVIDER IN THE ACADEMY**. I have acquired the education or licensure/certification, or formal appointment relevant and customary for a Physician Assistant or Nurse Practitioner.

I attest that I currently work on an integrated rehabilitation team with a physiatrist. **My membership is sponsored by the following Academy member:**

Name of Physiatrist Sponsor\*:

\*Sponsors must be a current Fellow, Part-Time Fellow, or Associate member of AAPM&R in good standing. The sponsoring member will be required to confirm that he/she works with the applicant on an integrated rehabilitation team.

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

## HOW DID YOU HEAR ABOUT US?

Colleague      AAPM&R Website      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

Physician Assistant	\$195 (USD)
Nurse Practitioner	\$195 (USD)

### 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](mailto: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](http://www.aapmr.org).

**aapm&r**

American Academy of  
Physical Medicine and Rehabilitation

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