



SAPA



Society of Army Physician Assistants

"A Civilian Organization Representing Army PA's"

Type of Application: Initial Renewal Change of Address, Info only

Rank _____ Last Name _____ First Name _____ MI _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone _____ Work _____ FAX _____

E-Mail Address _____

MILITARY INFORMATION

Active USAR NG Retired Civilian Other Military Service (Please Specify)

Current Assignment: _____

PROFESSIONAL INFORMATION

AHS/IPAP PA Class No: _____ Location of Preceptorship _____ Dates Attended: _____
(or)

Name/Location of Civilian/other military PA Program: _____ Dates Attended: _____

NCCPA # _____ Expiration Date _____ AAPA # _____ Expiration Date: _____

Do you wish to name SAPA as your constituent chapter of AAPA? YES NO

Highest Education Degree Attained: (Please Circle) AA AS BA BS MA MS PhD Other: _____

I hereby authorize SAPA to release information on this application to: SAPA Officers/Newsletter Staff: Yes No

Medical Professional Use: Yes No Third Party: Yes No

SIGNATURE: _____ DATE _____

No portion of your membership dues are used for lobbying purposes.

Membership dues: Fellow/Associate/Affiliate: \$25.00 per year. Student: \$5.00 per year

******* You May Pay For Multiple Years @ \$25 per year ***** Please mail dues to the address listed below:**

Method of Payment: Cash Check Credit Card (Circle one) Mastercard Visa Amer Exp

Credit Card Number: _____ Expiration Date: _____ Amount to be charged: _____

"I authorize SAPA to Charge My Credit Card for payment of my dues" (print and sign name as shown on credit card)

Print name: _____ Signature Required for Credit Card Use: _____

OFFICE USE ONLY: Date Received: _____ Amount Received: _____ How Paid _____

Mail Form to: SAPA, PO BOX 07490, Ft. Myers, Florida 33919 or fax to: (239) 482-2162