APPLICATION FOR MEMBERSHIP (PLEASE TYPE OR PRINT)

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.

Dues: Fellow/Associate/Affiliate $35.00 per year. **Fellow/Associate over 65**: $15.00 per year. **Student:** $5.00 per year

***** You May Pay For Multiple Years: @$35 per year x ______ years. 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 623, Monmouth, Illinois, 61462 or fax to: (309) 734-4489