



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 \$37.00 per year. Fellow/Associate over 65: \$15.00 per year. Student: \$5.00 per year
***** You May Pay For Multiple Years: @\$37 per year x _____ years. Please mail dues to the address listed below:**

FOR PAYPAL Payments from WWW.SAPA.ORG to the SAPA.MEMBERSHIP@gmail.com Paypal Account

******* You May Pay For Multiple Years @ \$37 per year ***** Please email form to SAPA.Membership@gmail.com or FAX to the number listed below:**

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