

BELOW ARE THE STEPS FOR OBTAINING APMA AND COMPONENT MEMBERSHIP FOR DPMS WITHIN THE UNITED STATES (NOT CURRENTLY IN A POSTGRADUATE PROGRAM).

1. LOCATE THE APPROPRIATE COMPONENT CONTACT INFORMATION BY GOING TO www.apma.org/statecomponents. CONTACT THE COMPONENT SOCIETY WHERE YOUR PRIMARY PRACTICE IS LOCATED. THEY WILL PROVIDE YOU WITH DETAILS ON MEMBERSHIP PROCESSING AND DUES PAYMENTS.
2. PRINT THE BELOW MEMBERSHIP APPLICATION.
3. COMPLETE THE APPLICATION AND MAIL DIRECTLY TO THE APPROPRIATE COMPONENT. MAKE SURE YOU PROVIDE A COPY OF ALL OF YOUR STATE LICENSES, STATIONERY, AND BUSINESS CARD. REMEMBER TO INCLUDE YOUR COMPONENT AND NATIONAL DUES.
4. UPON RECEIPT YOUR COMPONENT WILL COMPLETE PROCESSING TO ACTIVATE YOUR MEMBERSHIP. YOUR COMPONENT WILL FORWARD APPROPRIATE DOCUMENTATION AND DUES PAYMENT TO APMA AND YOU WILL BEGIN TO RECEIVE APMA MEMBER BENEFITS.
5. IF YOU HAVE ANY QUESTIONS, CALL THE APMA MEMBERSHIP SERVICES DEPARTMENT AT 1-800-ASK-APMA.

Web site: www.apma.org
E-mail: membership_ask_apma@apma.org
1-800-ASK-APMA

Application for Membership

I hereby apply for membership in the component association of the state in which I have my principal practice and to the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulations of my component association and the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

**Please Type
or Print Clearly.**
 Attach additional sheet
 of paper if needed.

Birth date, gender,
 and ethnic group
 are requested for
 statistical purposes.

Last Name _____ First _____ Middle _____

Previous Last Name (Changed due to marriage, divorce, etc.) _____

Birth Date ____ / ____ / ____ Nickname _____

Social Security No. (Optional): _____ Gender: M F

Ethnic Group (for demographic use only): White African American Hispanic American Indian
 Asian/Pacific Other _____

Spouse's Name _____ US Citizen (Optional): Yes No

**Complete all
addresses below.**

Please note your preferred
 mailing address by placing a
 check mark in the box to the
 left of that address.

*Your home address is
 essential for identifying
 and contacting your federal
 and state legislators through
 APMA's e-Advocacy program.

**APMA communicates many
 important issues via e-mail.
 Please be aware that
 your e-mail will **NOT** be
 shared with outside vendors.

Home Address*: _____

_____ County _____

Telephone () _____ Fax () _____

Home e-mail***: _____

Principal Office/Residency Address: _____

_____ County _____

Telephone () _____ Fax () _____

Office e-mail***: _____ Office Web Site: _____

Second Office Address: _____

_____ County _____

Telephone () _____ Fax () _____

Office e-mail***: _____ Office Web Site: _____

Third Office Address: _____

_____ County _____

Telephone () _____ Fax () _____

Office e-mail***: _____ Office Web Site: _____

If you have more than three office addresses, please list on a separate sheet.

Education

Undergraduate Degree

Year _____ State _____ Institution _____ Degree _____

Graduate Degree

Year _____ State _____ Institution _____ Degree _____

Podiatric Medical Degree

(see back panel for listings)

Check College Below Year of Graduation _____ Arizona Barry California
 Des Moines New York Ohio Temple Scholl Other _____

Postgraduate Education

Yes If yes, complete No

Fellowship

Residency (check one only):

- Rotating Podiatric Residency (RPR) Podiatric Orthopedic Residency (POR)
 Primary Podiatric Medical Residency (PPMR) Primary Surgical Residency (PSR)
 Podiatric Medicine and Surgery Residency (PM+S)

Begin Date _____ State _____ Institution _____ Completion Date _____
mo / yr mo / yr

Fellowship

Residency (check one only):

- Rotating Podiatric Residency (RPR) Podiatric Orthopedic Residency (POR)
 Primary Podiatric Medical Residency (PPMR) Primary Surgical Residency (PSR)
 Podiatric Medicine and Surgery Residency (PM+S)

Begin Date _____ State _____ Institution _____ Completion Date _____
mo / yr mo / yr

Military

Military Service

USA USAF USN USMC USCG Other _____

Date Entered _____ Date Separated _____ Current Rank _____

Reserves If yes, branch of service _____

Professional Licensure

Podiatric Medical Licenses

Year _____ State _____ Number _____ Year _____ State _____ Number _____

Year _____ State _____ Number _____ Year _____ State _____ Number _____

Year _____ State _____ Number _____ Year _____ State _____ Number _____

Have you ever had a license to practice podiatric medicine suspended or revoked by any licensure authority?

Yes No If yes, please explain on a separate sheet.

Are you currently, or have you ever been, on probation, suspension, or investigation by any licensure authority, state or federal agency?

Yes No If yes, please explain on a separate sheet.

Podiatric Medical Practice

Original Practice Start Date

Month _____ Day _____ Year _____

APMA-Recognized Organizations

(check only those in which you have certification/membership)

Board Certification (see back panel for listings)

ABPS ABPOPPM

Affiliated Membership (see back panel for listings)

AAHHP AAPP AAPSM AAWP ACFAOM
 ACFAP APMWA ASPD ASPM

Previous Member of APMA

Yes If yes, complete No

Dates _____ Component Association _____

Signature/Instructions

Please submit a sample of your stationery, business card and a copy of all state licenses with this application.

I understand that dual membership (state component and national association) is required to be a member in good standing. I agree not to represent myself as a member of APMA or my component, if for any reason, I cease to be a member in good standing. I also understand that a portion of my annual dues is in payment for a one year subscription for the *APMA NEWS* and for the *Journal of the American Podiatric Medical Association*. I agree that incomplete or false information may be grounds for denial or termination of membership.

APMA dues are not deductible as a charitable contribution for federal tax purposes but may be deductible as a business expense.

If you are a practicing DPM, it is important to contact the state component in which your primary practice is located. Contact information can be found on-line at www.apma.org/StateComponents. Your component will inform you of the amount of dues to remit as well as any other required documentation. An overview of membership processing procedures of each state component can be viewed at www.apma.org/MembershipProcess. Your completed application and dues payment must be sent directly to your state component, not the APMA.

If you are a DPM in post-graduate training, send your completed application and dues payment directly to APMA. A current dues chart for DPMs in post-graduate training can be viewed at www.apma.org/PostGraduateDuesSchedule.

If you have any questions, please contact the APMA Membership Services department at 1-800-ASK-APMA.

Applicant Signature: _____, DPM Date: _____

I was recruited for APMA membership by the following APMA member: _____

Listing of Podiatric Medical Colleges

Arizona:	Arizona Podiatric Medicine Program at Midwestern University—Glendale
Barry:	Barry University School of Graduate Medical Sciences
California:	California School of Podiatric Medicine at Samuel Merritt College
Des Moines:	Des Moines University College of Podiatric Medicine & Surgery
New York:	New York College of Podiatric Medicine
Ohio:	Ohio College of Podiatric Medicine
Temple:	Temple University School of Podiatric Medicine
Scholl:	Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine & Science

Listing of Boards

ABPOPPM	American Board of Podiatric Orthopedics and Primary Podiatric Medicine
ABPS	American Board of Podiatric Surgery

Listing of Affiliated Organizations

AAHHP	American Association of Hospital and Healthcare Podiatrists
AAPPM	American Academy of Podiatric Practice Management
AAPSM	American Academy of Podiatric Sports Medicine
AAWP	American Association for Women Podiatrists
ACFAOM	American College of Foot and Ankle Orthopedics and Medicine
ACFAP	American College of Foot and Ankle Pediatrics
APMWA	American Podiatric Medical Writers' Association
ASPD	American Society of Podiatric Dermatology
ASPM	American Society of Podiatric Medicine

For Component Society Use

Component name: _____

Division (If applicable): _____

Date application was received: _____

Date sent to APMA: _____

Join date: _____

Member category: _____

For APMA Use Only

Dues Amount	_____
Member No.	_____
Member Type	_____
Date Received	_____
Elect Date	_____