AAAM Membership Application Form

Fast Join at: www.aaamed.org/Mbr_Join.cfm

Your information:

Title: ☐ Dr. ☐ Prof. ☐ Mrs. ☐ Mr.

First Name:_____Middle Name:_____

Last Name/Surname:_____

Designation: ☐ MD ☐ DO ☐ DDS ☐ PhD ☐ ND Other_____

Your name as you wish it to appear on your AAAM Membership Certificate (example: John R. Smith, MD):

_____

Practice/Organization Name (Leave blank if none):_____

Field of Medical Practice (Example: General Practitioner):_____

Mailing Address: _____

Mailing Address Line 2 (If necessary):_____

City:_____US State or Province:_____Country:_____

Zip Code/Postal Code:_____Telephone:_____

Fax:_____Email:_____Website:_____

Membership Categories:

☐ Regular Member (US $175.00) (Physicians only)

☐ Associated Member (US $250.00) (Industry, Pharmacists, Chemists, etc.)

☐ Sponsorship Member (US $2,500.00)

Payment: ☐ Check ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Name that appears on the credit card:_____

Credit Card Number_____Expiration (month/year _____

CSV Code (3 digit code on back of card) _____ ☐ I authorize AAAM to charge my credit card . Amt:$_____

Credit Card billing address if different than above:_____

_____

AAAM Contact and Mailing Information:

If paying by **cheque**, make check payable to **AAAM** and mail to:

Mail: AAAM Membership

3151 Barkentine Road, Rancho Palos Verdes, CA 90275 USA

Fax to **+1-310-347-4421** or **email** to info@aaamed.org with payment details.

Your application will be confirmed by email when your payment is processed. Your AAAM Membership Certificate will be mailed within 2 weeks. Please allow an additional 2 weeks for mail sent outside the US.

All **enquiries**, contact **Ellen Dahlin** at **+1-310-944-1790** (US Pacific Time Zone)