



# AAAM Membership Application Form

Fast Join at: [www.aaamed.org/Mbr\\_Join.cfm](http://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](mailto: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)