AMERICAN ACADEMY OF ANESTHESIOLOGIST ASSISTANTS

1231 Collier Rd NW Suite J • Atlanta, GA 30318 • Phone: 678-222-4233 • Fax: 404-249-8831 www.anesthetist.org • info@anesthetist.org

Physician Affiliate Membership Application

PLEASE PRINT OR TYPE

Full Name + Degrees/Credentials: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____ **Cell:** ( ) _____

Fax: ( ) _____ **Primary E-Mail:** _____

Member's Only Access Information*:

Username: _____ Password: _____

*You will use this login information to access your online membership profile on the AAAA website.

❒ I do not wish to have any of my information released outside of the AAAA office without my permission.

EMPLOYER INFORMATION

Practice Group: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Work E-Mail: _____ **Job Title:** _____

Work Phone: _____ **Work Fax:** _____

Please check any areas in which you would like to participate below:

❒ Annual Meeting ❒ Membership ❒ Practice ❒ Communication/News

❒ National Affairs ❒ Student Affairs ❒ State Affairs ❒ Education

PAYMENT INFORMATION (Physician Affiliate membership: $150/year)

❒ I'd like to make a Legislative Fund contribution (Optional) $ _____

☐ Single Payment ☐ Reoccurring Quarterly Contribution ☐ Recurring Monthly Contribution

❒ Check enclosed ❒ Mastercard ❒ VISA ❒ AMEX ❒ Discover

TOTAL PAID: $_____

Name on Card: _____ **Card #:** _____

Expiration Date: _____ CCV _____ **Signature:** _____

Please send your completed application and check, payable to AAAA, to:
AAAA • 1231 Collier Rd. NW, Ste J • Atlanta, GA 30318

Referred by:

_____

If someone referred you to AAAA, please list his/her name. Any member who refers two (2) non-student members to AAAA receives a $50 discount on next year's dues. Referred members cannot have been a member for at least one year.

Authorization to Verify Application Information

I hereby authorize the American Academy of Anesthesiologist Assistants (AAAA), or any of its officers, employees or agents, to investigate and verify the information I have set forth on my application to be a member of the American Academy of Anesthesiologist Assistants (AAAA).

I understand the authority I am granting the AAAA and further understand that said verification of the information set forth on the application is a requirement to my becoming a member of the above-named organization.

Signature: _____ Date: _____