



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

Student Membership Application

PLEASE PRINT OR TYPE

Full Name + Degrees/Credentials: _____ Birthdate: _____

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.

STUDENT INFORMATION

AA Program: _____

School Information/Program: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Graduation Date: _____

States of Interest (List all that apply):

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Annual Meeting | <input type="checkbox"/> Membership | <input type="checkbox"/> Practice | <input type="checkbox"/> Communication/News |
| <input type="checkbox"/> Federal Affairs | <input type="checkbox"/> Student Affairs | <input type="checkbox"/> State Affairs | <input type="checkbox"/> Education |

PAYMENT INFORMATION (Student membership dues \$200/year)

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Single Payment | <input type="checkbox"/> Reoccurring Quarterly Contribution | <input type="checkbox"/> Recurring Monthly Contribution |
|---|---|---|

TOTAL PAID:

Check enclosed MasterCard VISA AMEX \$ _____

Name on Card: _____ Card #: _____

Expiration Date: _____ Signature: _____

Please send your completed application and check, payable to AAAA, to:

AAAA • Attention: Stephanie Bowen • 1231 Collier Rd. NW, Ste J • Atlanta, GA 30318

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: _____

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.