



American Association of Physicians of Indian Origin

Executive Headquarters: 600 Enterprise Drive Suite 108, Oak Brook, IL 60523

Telephone: (630) 990-2277, Fax: (630) 990-2281

AAPI Tax ID: 38-2532505 www.aapiusa.org

AAPI 2018-19 Membership Application

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Home Office

City: _____ State: _____ Zip: _____ Gender: _____

Home Phone: _____ Office Phone: _____ Fax: _____

Email (*unique*): _____ Date of Birth: _____

Med School: _____ Start Year _____ End Year _____

Residency Institution: _____ Start Year _____ End Year _____

Fellowship Institution: _____ Start Year _____ End Year _____

Primary Specialty: _____ Secondary Specialty: _____

*** Training Level (Circle one):** Attending Young Physician Fellow Resident Medical Student
 Attending/GC BACKLOG

If Young Physician, please select which year you are in.) 1 2 3 4 5 6 7 8

If Medical Student or Resident or Fellow - please select one:

- Medical Student** – Anticipated year of completion _____ (*Not eligible for Patron Membership*)
- Resident** – Anticipated year of completion _____ Specialty _____
- Fellow** – Anticipated year of completion _____ Specialty _____

***MEMBERSHIP CATEGORIES:**

- \$500 \$250 \$100 Patron (Life) Membership (Promotion till November 17, 2019)**
(Attending Physicians, Young Physicians in their first 8 years of practice, Residents and Fellows only)
- \$100 Annual Membership for Attending Physicians**
- \$50 Annual Membership for Young Physicians (YPS)**
- \$0 Annual Membership for Medical Student/Resident/Fellow (MSRF)**

To Pay by Credit Card, please mail this application along with your Credit Card Information to:

AAPI Executive Office; 600 Enterprise Drive, Suite 108, Oak Brook, IL 60523 **or Fax it to: (630) 990-2281**

Payment shall be made by personal credit card, personal check or by employer check only.

PAYMENT INFO Visa American Express Master Card Discover

Credit Card Number: _____ Exp. Date: _____ CVV: _____

Card Holder's Name: _____ Signature: _____

Credit Card Billing Address (if different than above): _____

I agree to pay the total amount according to USA card issuer agreement. All credit card transactions are processed in U.S. dollars and are subject to the current exchange rates.

To Pay by Check, please mail this application along with your check to:

American Association of Physicians of Indian Origin, 600 Enterprise Drive, Suite 108, Oak Brook, IL 60523

The information provided in this application are true and correct. Filling this application doesn't entitle me to be a member of AAPI. I understand that the AAPI Membership Committee will review my information provided in this application. If found not eligible for AAPI membership, I acknowledge that the dues paid are **non-refundable**.

As a member of AAPI, I will abide by the [AAPI Bylaws and it's Articles of Incorporation](#)

***Signature:** _____ **Date:** _____