



Please complete the following application and mail it with a copy of your current state veterinary license (required to process and activate your membership), to 100 W Coolidge St., Phoenix, AZ 85013.

****Optional - include a headshot for inclusion of our Annual Membership Directory****

Applicant Information

Name: _____

Home Address: _____

Phone: _____ Cell: _____ Date of Birth: ____/____/____ Male Female

Email: _____ Alternate Email: _____

Degree: _____ Diplomate/Certification: _____

School Year Degree

Mail to: Home Business

Business Information

Practice Name: _____ Owner Responsible Veterinarian Associate

Practice Address: _____ City State Zip

Business Phone: _____ Fax: _____ Type of Practice: Small Large Mix Relief Academic

Website: _____ Exotics Zoo Mobile Gov't Equine

Do You Provide: Boarding Grooming Microchipping Licensing

Areas of Interest

Please select up to **FIVE (5)** Areas of Interest to list in your Annual Membership Directory profile.

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Hematology	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Soft Tissue Surgery
<input type="checkbox"/> Allergy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Immunology	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Alternative Therapy	<input type="checkbox"/> Emergency	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pathology	<input type="checkbox"/> Stem Cell Therapy
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Intensive Care	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Surgery
<input type="checkbox"/> Avian	<input type="checkbox"/> Endoscopy	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Preventative	<input type="checkbox"/> Toxicology
<input type="checkbox"/> Behavior	<input type="checkbox"/> Epidemiology	<input type="checkbox"/> Lameness	<input type="checkbox"/> PT/Rehab	<input type="checkbox"/> TPLO Certified
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Equine	<input type="checkbox"/> Laser Surgery & Therapy	<input type="checkbox"/> Public Health	<input type="checkbox"/> Urology
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Exotics	<input type="checkbox"/> Neurology	<input type="checkbox"/> Radiology	<input type="checkbox"/> Vestibular Disease
<input type="checkbox"/> Coccidioidomycosis	<input type="checkbox"/> Genetics	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Reproduction	<input type="checkbox"/> Wildlife
<input type="checkbox"/> Diagnostic Screening	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Oncology	<input type="checkbox"/> Reptiles	
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Hearing	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Shelter Medicine	

Signature constitutes acceptance of and intention to be bound by the Articles of Incorporation, Constitution, and Bylaws of this Association and the Principles of Veterinary Medical Ethics of the American Veterinary Medical Association together with all amendments, present and future, of such Articles, Constitution, Bylaws, or Principles of Veterinary Medical Ethics which may be duly adopted pursuant to the provisions thereof, and to continuously strive for the advancement of the profession. I am aware that my application must be accompanied by a copy of my current state veterinary license or acceptable alternative and approved by the Board of Directors. If there are changes to my contact information, I understand it is my responsibility to update my member profile online or notify the AzVMA office in writing immediately. Questions should be sent to membership@azvma.org or call the AzVMA office at 602-242-7936.

Signature: _____ Date: _____