IAPA
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Boise, ID 83701
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Fax: (208) 344-7903
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www.idahopa.org

2016 New Membership Application

Sign up/Renew online or use this form!

Note: This application must be completed in entirety, signed, dated, and submitted with payment prior to consideration.

The IAPA is the voice of PAs in Idaho; leading through education, advocacy, community involvement and professional growth.

Membership Categories: *(Choose only ONE Category)*

☐ **Fellow Dues: $125.00** (AAPA Member) Physician assistants who practice within the State of Idaho and are members of the AAPA. Full voting privileges for both the IAPA and AAPA.	☐ **Colleague Dues: $125.00** (Non-AAPA Member) Physician assistants who practice within the State of Idaho and are not current members of the AAPA. Eligible voting privileges for the IAPA only.
☐ **Affiliate Dues: $45.00** Individuals who are not physician assistants (NP's, MD's, MS's) as recognized by the NCCPA and AAPA, but wish to belong to the IAPA.	☐ **Out of State Dues: $45.00** Physician assistants who reside or practice in other states who wish to belong to the IAPA. Entitled to privileges of the floor at annual conferences, but may not vote or hold office.
☐ **Sustaining Dues: $45.00** Physician assistants who are retired, employed by a Federal agency, or are in active duty military. Entitled to privileges of the floor at annual conferences, but may not vote or hold office.	☐ **Student Dues: $20.00** Student must be currently enrolled in good standing in an ARC-PA accredited PA program of study. May not vote, nor be able to hold state office except for the position of student representative. Entitled to privileges of the floor at annual conferences and/or meetings.

Payment Options:

❑ Check enclosed *(payable to IAPA).*

Credit Card:

❑ MasterCard ❑ Visa ❑ American Express ❑ Other ______________

Credit Card Information:

Card Number ______________ CVV (back of card) ______________ Exp. Date ______________

Billing Address ______________

Name as it appears on credit card ______________ Signature of cardholder ______________

Membership Information: *(You may also update this information online!)*

Business Information:

First Name ______________ M.I. ______________ Last Name ______________

Organization or Company Name ______________

Address ______________

City ______________ State ______________ Zip ______________

Phone ______________ Extension ______________ Fax ______________

Please Turn Over ⇨

E-Mail Cell Phone (We will not publish)

***All member information is sent by email. Please provide an address that you check.*

Office Manager's Email Address

Supervising Physician

Home Information:

Address

City State Zip

Phone Fax

E-Mail Cell Phone (We will not publish)

IAPA Volunteer Interests: *(Please select any areas of interest)*

❑ CME/Conference Committee ❑ Board Member