THE VOICE OF YOUR PROFESSION

ILLINOIS PODIATRIC MEDICAL ASSOCIATION
745 McClintock, Suite 340
Burr Ridge, Illinois 60527
Telephone: 312-427-5810 Fax: 312-427-5813

APPLICATION FOR MEMBERSHIP

Welcome Congratulations on making a milestone decision in your career. Membership in the Illinois Podiatric Medical Association and the American Podiatric Medical Association will benefit you throughout your professional lifetime as a podiatric physician.

Instructions Please complete all sections of this application. In the last section you will be instructed to stop and call the IPMA for the amount of dues which must accompany your application. When you have done so, mail this form and your payment to the IPMA at the address shown above.

Approval Process This application is subject to review and approval by the Board of Directors of the Illinois Podiatric Medical Association. If your application is complete and you meet the requirements for membership set forth in the IPMA and the APMA by-laws, then you are likely to be accepted into membership in both the state (IPMA) and national (APMA) organizations. Your membership will be unified, that is, you will be enrolled in both the state and the national organizations and eligible for their benefits and services. Your signature at the end of the application signifies your acceptance of the terms and conditions of membership, as well as your voluntary subscription to the Code of Ethics of the American Podiatric Medical Association.

Applicant Information

Name_____
Last First Middle Initial

Birth Date _____/____/_____ ❑ Male ❑ Female U.S. Citizen? ❑ Yes ❑ No

Spouse's Name_____

Ethnic Group (*for statistical purposes only*) ❑Caucasian ❑African American ❑Hispanic
❑Asian/Pacific American ❑Native American ❑Other _____

Practice Name _____

E-Mail Address _____ Web Site_____

Office and Home Addresses

*Check **ONE** address for all IPMA mailings*

❑ Home Address _____

_____
City State Zip County

(_____)_____(_____)_____
Telephone Fax

❑ Primary Office _____

_____
City State Zip County

(_____)_____(_____)_____
Telephone Fax

❑ Second Office _____

_____
City State Zip County

(_____)_____(_____)_____
Telephone Fax

(If you have more than 2 offices, please list them on a separate sheet.)

Education

Undergraduate Degree Institution_____

Year _____ State _____ Degree _____

Graduate Degree Institution_____

Year _____ State _____ Degree _____

Podiatric Medical Degree Year _____ College: ❑Barry ❑ CCPM ❑ Iowa ❑ NYCPM ❑ OCPM ❑ Scholl ❑ Temple ❑ Other: _____

Postgraduate Education *(If you have more residencies/fellowships, please list on a separate sheet)*

❑ **Residency #1**

❑ Podiatric Medical Surgical Residency ❑Other _____

Institution _____

City/State _____Begin Date _____ End Date_____

❑ **Residency #2 OR ❑Fellowship** *(check one only)*

❑ Podiatric Medical Surgical Residency ❑Other _____

Institution _____

City/State _____Begin Date _____ End Date_____

Military

Military Service ❑USA ❑ USAF ❑USN ❑USMC ❑USCG ❑ Other: _____

Date Entered _____ Date Separated _____ Current Rank _____

State Licensure

Podiatric Medical Licenses Year_____ State _____ Number _____

Year_____ State _____ Number _____

Year_____ State _____ Number _____

Have you ever had a license to practice podiatric medicine suspended or revoked by any licensure authority?

❑ Yes ❑ No *If yes, please explain on a separate sheet.*

Are you currently, or have you ever been, on probation or suspension or under investigation by any licensure authority, state or federal agency?

❑ Yes ❑ No *If yes, please explain on a separate sheet.*

Medical Practice

Practice Start Date *(month/date/year)* _____ ❑Solo ❑Group ❑Other

Affiliations

			Type of Institution *(Check One)*		
Year	**State**	**Institution**	**Hospital**	**PPO**	**HMO**

Certification ❑ ABPS ❑ ABPO/PPM ❑ Other: _____

Affiliated/Related Memberships

- ❑ AAPPM American Academy of Podiatric Practice Management
- ❑ AAPSM American Academy of Podiatric Sports Medicine
- ❑ AAHHP American Association of Hospital and Healthcare Podiatrists
- ❑ AAWP American Association of Women Podiatrists
- ❑ ACFAOM American College of Foot and Ankle Orthopedics and Medicine
- ❑ ACFAP American College of Foot and Ankle Pediatrics
- ❑ ACFAS American College of Foot and Ankle Surgeons
- ❑ ACPMR American College of Podiatric Medical Review
- ❑ ACPR American College of Podiatric Radiologists
- ❑ APCS American Podiatric Circulatory Society
- ❑ APMWA American Podiatric Medical Writers Association
- ❑ ASPD American Society of Podiatric Dermatology
- ❑ ASPM American Society of Podiatric Medicine
- ❑ ASPS American Society of Podiatric Surgeons
- ❑ CMMT Conference on Multi Cultural Membership and Talents

Faculty Status (*Current Position Information Only*) ❑Part-time ❑Full-time
❑Adjunct ❑Clinical ❑Emeritus ❑Visiting ❑Instructor ❑Associate Professor
❑Assistant Professor ❑Other_____

Institution _____ Start Date _____

Consultant Position (*Current Position Information Only*) ❑Part-time ❑Full-time
❑Insurance Carrier ❑PRO ❑UR Firm ❑Other_____

Institution _____ Start Date _____

Previous APMA Membership

If you have ever been a member of the APMA, please provide the following:

Member Number _____ Membership Dates _____ State Association _____

Stop Now!

Call the IPMA at 312-427-5810

Monday – Friday, 9:00 a.m. to 5:00 p.m.

for the payment information needed to complete your application.

Membership Type and Dues Payment

Membership Category _____

Initial Dues *IPMA and APMA dues are to be included with this application.*

APMA $ _____ IPMA $ _____ **Total $ _____**

Payment ❑ Check *Make all checks payable to **Illinois Podiatric Medical Association.***

❑ Charge Card: ❑ MasterCard ❑ Visa ❑ Discover ❑ American Express

Name on card _____

Card Number _____

Expiration Date _____Security Code _____

Signature _____

Please continue to page 4 to complete your Pledge of Membership

THIS SECTION FOR USE BY THE IPMA AND APMA STAFF ONLY

IPMA	APMA
Date completed application received _____	Dues Amount $ _____
Amount of Dues Received: Total _____	Member Number _____
APMA $ _____ IPMA $_____	Date Received _____
Zone Organization _____	Elect Date _____
Date application was considered _____	
Action Taken ❑ Approved ❑Denied	

Your Pledge of Membership

I hereby make application for membership in the Illinois Podiatric Medical Association (IPMA), because my principle practice is in the state of Illinois and to the American Podiatric Medical Association (APMA). I understand that dual membership (State component and National association) is required to be a member in good standing. If elected to membership, I agree to uphold and abide by the purposes, constitution and by-laws, Code of Ethics, and all rules and regulations of the Illinois Podiatric Medical Association and the American Podiatric Medical Association.

I understand that all emblems and certificates are and remain the property of the Illinois Podiatric Medical Association and/or the American Podiatric Medical Association and are only held in trust. I agree to return them to the Secretary of the Illinois Podiatric Medical Association if for any cause or reason I cease to be a member in good standing of either the IPMA or the APMA. I also understand that a portion of my annual dues is in payment for a one-year subscription to the *Journal of the American Podiatric Medical Association* and the *APMA NEWS*,

APMA and IPMA dues are not deductible as a charitable contribution for federal tax purposes but may be deductible as a business expense.

Applicant Signature _____

Date _____

Your signature on this application confirms your understanding of the terms and conditions of membership and the privileges included.

Please send this completed application with your payment for initial dues to:

Illinois Podiatric Medical Association
ATTN: Membership Manager
745 McClintock Dr., Suite 340
Burr Ridge, IL 60527
or
FAX (312) 427-5813

IPMA
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