



Important Notice: Please fill out this application legibly. DPM's applying for membership must be a member in good standing with the **APMA**. Please Note: A \$25.00 fee will be charged on all returned checks.

DPM \$100.00 (one-time membership fee)

Podiatrist Name: _____ APMA#: _____

Office: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The application fee must accompany this form. Checks should be made payable to ASPMA. Remember DPM's must recertify every May with 20 CME's and a \$55.00 recertification fee.

Send completed membership form and payment to: Tina Phelps, PMAC
ASPMA Membership Chair
602 Bradley Dr. Apt A
Fortville, IN 46040

If you have any questions, please call the ASPMA Office at 1-888-88ASPMA or email us at aspmalex@aol.com.

For Office Use Only Check#: _____ Date Rcv'd: _____ Amount: _____