IMPORTANT: Prior to submitting application, please contact PPMA to determine the appropriate dues amount.

Email: Jenna@ppma.org    Phone: 717-763-7665 x13    Fax: 717.761.4091

Mail the completed application, along with your dues payment, to:

Pennsylvania Podiatric Medical Association
757 Poplar Church Road
Camp Hill, PA 17011-2314

Make checks payable to PPMA -- Visa, MasterCard, American Express & Discover accepted
Application for Membership

I hereby apply for membership in the component association of the state in which I have my principal practice and to the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulations of my component association and the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

Last Name _________________________________ First _______________________ Middle ____________
Previous Last Name (Changed due to marriage, divorce, etc.)_____________________________________
Birth Date  ________ / ________  / __________ Nickname ________________________________________
Social Security No. (Optional): _________________________    Gender: ☐ M ☐ F
Ethnic Group (for demographic use only): ☐ White ☐ African American ☐ Hispanic ☐ American Indian
☐ Asian/Pacific ☐ Other_____________________________________
Spouse’s Name___________________________________________ US Citizen (Optional): ☐ Yes ☐ No

☒ Home Address*:  ______________________________________ County _______________________________
Telephone (    ) __________________________________________ Fax (    ) __________________________
Home e-mail**: __________________________________________

☒ Principal Office/Residency Address: __________________________ County _______________________________
Telephone (    ) __________________________________________ Fax (    ) __________________________
Office e-mail**: __________________________________________ Office Web Site: _________________________

☒ Second Office Address: __________________________________________ County _______________________________
Telephone (    ) __________________________________________ Fax (    ) __________________________
Office e-mail**: __________________________________________ Office Web Site: _________________________

☒ Third Office Address: __________________________________________ County _______________________________
Telephone (    ) __________________________________________ Fax (    ) __________________________
Office e-mail: ** __________________________________________ Office Web Site: _________________________

If you have more than three office addresses, please list on a separate sheet.

Please Type or Print Clearly. Attach additional sheet of paper if needed. Birth date, gender, and ethnic group are requested for statistical purposes.

Complete all addresses below.

Please note your preferred mailing address by placing a check mark in the box to the left of that address.

*Your home address is essential for identifying and contacting your federal and state legislators through APMA’s e-Advocacy program.

**APMA communicates many important issues via e-mail. Please be aware that your e-mail will NOT be shared with outside vendors.
**Education**

<table>
<thead>
<tr>
<th>Undergraduate Degree</th>
<th>Year</th>
<th>State</th>
<th>Institution</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Graduate Degree</th>
<th>Year</th>
<th>State</th>
<th>Institution</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Podiatric Medical Degree**

(see back panel for listings)

Check College Below

- Arizona
- Barry
- California
- Des Moines
- New York
- Ohio
- Temple
- Scholl
- Other

**Postgraduate Education**

[ ] Yes [ ] If yes, complete [ ] No

[ ] Fellowship

[ ] Residency (check one only):

- Rotating Podiatric Residency (RPR)
- Podiatric Orthopedic Residency (POR)
- Primary Podiatric Medical Residency (PPMR)
- Primary Surgical Residency (PSR)
- Podiatric Medicine and Surgery Residency (PM+S)

Begin Date _______ State ______ Institution __________________________ Completion Date _______

mo / yr

[ ] Fellowship

[ ] Residency (check one only):

- Rotating Podiatric Residency (RPR)
- Podiatric Orthopedic Residency (POR)
- Primary Podiatric Medical Residency (PPMR)
- Primary Surgical Residency (PSR)
- Podiatric Medicine and Surgery Residency (PM+S)

Begin Date _______ State ______ Institution __________________________ Completion Date _______

mo / yr

**Military**

**Military Service**

[ ] USA [ ] USAF [ ] USN [ ] USMC [ ] USCG [ ] Other

Date Entered __________________ Date Separated ________________ Current Rank ________________

[ ] Reserves [ ] If yes, branch of service __________________________

**Professional Licensure**

**Podiatric Medical Licenses**

<table>
<thead>
<tr>
<th>Year</th>
<th>State</th>
<th>Number</th>
<th>Year</th>
<th>State</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, suspension, or investigation by any licensure authority, state or federal agency?

[ ] Yes [ ] No [ ] If yes, please explain on a separate sheet.

**Podiatric Medical Practice**

**Original Practice Start Date**

Month _______ Day _______ Year _______
APMA-Recognized Organizations
(check only those in which you have certification/membership)

Board Certification
(see back panel for listings)
- ABPS  - ABPOPPM

Affiliated Membership
(see back panel for listings)
- AAHHP  - AAPPM  - AAPSM  - AAWP  - ACFAOM  
- ACFAP  - APMWA  - ASPD  - ASPM

Previous Member of APMA

- Yes  If yes, complete  - No

Dates _______________ Component Association ______________________________________________

Signature/Instructions

Please submit a sample of your stationery, business card and a copy of all state licenses with this application.

I understand that dual membership (state component and national association) is required to be a member in good standing. I agree not to represent myself as a member of APMA or my component, if for any reason, I cease to be a member in good standing. I also understand that a portion of my annual dues is in payment for a one year subscription for the APMA NEWS and for the Journal of the American Podiatric Medical Association. I agree that incomplete or false information may be grounds for denial or termination of membership.

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

If you are a practicing DPM, it is important to contact the state component in which your primary practice is located. Contact information can be found on-line at www.apma.org/StateComponents. Your component will inform you of the amount of dues to remit as well as any other required documentation. An overview of membership processing procedures of each state component can be viewed at www.apma.org/MembershipProcess. Your completed application and dues payment must be sent directly to your state component, not the APMA.

If you are a DPM in post-graduate training, send your completed application and dues payment directly to APMA. A current dues chart for DPMs in post-graduate training can be viewed at www.apma.org/PostGraduateDuesSchedule.

If you have any questions, please contact the APMA Membership Services department at 1-800-ASK-APMA.

Applicant Signature: ______________________________________, DPM  Date: ______________

I was recruited for APMA membership by the following APMA member: ______________________________
For Component Society Use

Component name:______________________________________
Division (If applicable):________________________________
Date application was received:___________________________
Date sent to APMA:_____________________________________
Join date:______________________________________________
Member category:______________________________________

For APMA Use Only

Dues Amount _______________
Member No. _______________
Member Type _______________
Date Received _______________
Elect Date _______________