

# ACTIVATE YOUR RPA MEMBERSHIP TODAY.



**Call:** (301) 468-3515    **Fax:** (301) 468-3511

## Mail:

**Renal Physicians Association**  
1700 Rockville Pike, Suite 220  
Rockville, MD 20852

**Online:** [www.renalmd.org](http://www.renalmd.org)

## Membership categories and dues rates

(Please indicate your membership category below)

### Physician

- \$415—Adult or Pediatric (circle one)
- \$200 Young Physician (nephrologists who are 40 years old or younger and provide birthdate)  
Please designate one:
  - Young Physician Pediatric Nephrologist
  - Young Physician Adult Nephrologist
- \$100 Retired (working 0 hours)

### Fellows (in training)

- \$0—Associate
- Name of current training program facility and expected completion date:

\_\_\_\_\_  
*Training Program Facility*                      *Completion Date*

License #: \_\_\_\_\_ State: \_\_\_\_\_

### Practitioners

- \$275 Practice Managers
- \$275 Advanced Practice Nurses
- \$275 Physician Assistant

You must list a professional reference who is an RPA nephrologist member employed by the same practice as yourself.

### Full Name of:

Reference: \_\_\_\_\_

Telephone: \_\_\_\_\_

### Affiliates

- \$200 Electronic Membership (for anyone who is not an actively practicing physician or listed practitioner.)

Current Employer: \_\_\_\_\_

Current Job Title/Occupation: \_\_\_\_\_

\_\_\_\_\_

## 2017 Membership Application

RPA provides timely news, information about RPA products and services and other communications targeted to meet the needs of physicians. To receive these communications, please join today.

My email address is\*  
\*(A valid email is required with all credit card payments.)

\_\_\_\_\_  
*First Name*                      *Middle Initial*                      *Last Name*

Preferred professional mailing address:

- Home     Office     Both

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City*                                      *State*                      *Zip*

\_\_\_\_\_  
*Phone*                                      *Fax*

\_\_\_\_\_  
*Date of Birth*                                      *Gender*

- By checking this box I am requesting that information not be emailed or faxed to me.

- AMA Member (check if you are a member)

### Method of payment (see rate on left)

- Check (Please make your check payable to: Renal Physicians Association)
- Please charge my:
  - Visa     MasterCard     American Express

\*(A valid email is required with all credit card payments.)

- Automatic Dues Renewal

*By checking "Automatic Dues Renewal," I authorize RPA to retain my credit card information securely and to charge my credit card to pay my membership dues annually. I understand that my membership dues will automatically be charged to this credit card until RPA receives notification from me instructing association personnel to cancel my participation in Automatic Dues Renewal.*

\_\_\_\_\_  
*Credit Card number*                                      *Expiration Date*

\_\_\_\_\_  
*Signature*

**Membership dues must be submitted with the membership application. RPA will process payment after the application is approved. Individuals may join at any time during the year**

### For RPA Use:

Date Received: \_\_\_\_\_

Action:  Approved     Denied

\_\_\_\_\_  
*Officer Signature*                                      *Date*