

2019 Membership Renewal/Application

Name _____	Credentials _____
Preferred Address _____	<input type="radio"/> Work <input type="radio"/> Personal WI License # _____ AAPA Member # _____
Primary Organization _____	
Department/Division _____	
Work Address _____	Personal Address _____
Work City & County _____	Personal City & County _____
Work State/ZIP _____	Personal State/ZIP _____
Work Phone _____	Personal Phone _____
Primary Email _____	Alternate Email _____

Check here if you want to be a PA Preceptor. A WAPA representative will contact you.

<p>Please check your practice specialty:</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Addiction Medicine</td> <td><input type="checkbox"/> Family Practice</td> <td><input type="checkbox"/> Pediatrics</td> </tr> <tr> <td><input type="checkbox"/> Allergy, Asthma & Immunology</td> <td><input type="checkbox"/> Gastroenterology</td> <td><input type="checkbox"/> Plastic Surgery</td> </tr> <tr> <td><input type="checkbox"/> Anesthesia</td> <td><input type="checkbox"/> Hospice & Palliative Medicine</td> <td><input type="checkbox"/> Psychiatry</td> </tr> <tr> <td><input type="checkbox"/> Cardiology</td> <td><input type="checkbox"/> Nephrology</td> <td><input type="checkbox"/> Rheumatology</td> </tr> <tr> <td><input type="checkbox"/> Cardiovascular Surgery</td> <td><input type="checkbox"/> Neurosurgical</td> <td><input type="checkbox"/> Surgical</td> </tr> <tr> <td><input type="checkbox"/> Dermatology</td> <td><input type="checkbox"/> Obstetrics & Gynecology</td> <td><input type="checkbox"/> Urology</td> </tr> <tr> <td><input type="checkbox"/> Ear, Nose & Throat</td> <td><input type="checkbox"/> Occupational Medicine</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Emergency Medicine</td> <td><input type="checkbox"/> Oncology</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Endocrinology</td> <td><input type="checkbox"/> Orthopedic Surgery</td> <td></td> </tr> </table>	<input type="checkbox"/> Addiction Medicine	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Allergy, Asthma & Immunology	<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Hospice & Palliative Medicine	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Cardiology	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Cardiovascular Surgery	<input type="checkbox"/> Neurosurgical	<input type="checkbox"/> Surgical	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Obstetrics & Gynecology	<input type="checkbox"/> Urology	<input type="checkbox"/> Ear, Nose & Throat	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Other	<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Oncology		<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Orthopedic Surgery		<p>Please check your committee interest:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Education <input type="checkbox"/> Diversity <input type="checkbox"/> Legislative & Government Affairs <input type="checkbox"/> Membership <input type="checkbox"/> Professional Practice <input type="checkbox"/> Professional Wellness <input type="checkbox"/> Public Relations <input type="checkbox"/> Standing Rules & Policies <input type="checkbox"/> Website
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<input type="checkbox"/>	Fellow (\$150)	A fellow member of the AAPA, a Wisconsin PA on the active or inactive MEB list, or a Wisconsin PA who is NCCPA certified and a graduate of an AMA approved PA program.
<input type="checkbox"/>	Member (\$150)	Must meet the same qualifications as above except not an AAPA fellow member.
<input type="checkbox"/>	Affiliate (\$150)	An out-of-state PA or anyone not recognized as a PA by the MEB (not a graduate of an AMA approved PA program or not NCCPA certified) or a physician, nurse, administrator, etc.
<input type="checkbox"/>	Organizational (\$150)	Clinic, hospital, nursing home, university health service or other institution providing health care.
<input type="checkbox"/>	Sustaining (\$50)	Fellow or Member of WAPA for a minimum of five (5) preceding years AND has retired from clinical practice or is leaving clinical practice as a PA for an indefinite period of time. A PA who is employed on a more than casual call/PRN basis does not qualify.
<input type="checkbox"/>	Student (\$20)	Graduation Year: _____ PA School/Program: _____ <i>Fee covers membership through graduation. You will then receive complimentary fellow membership until the end of the calendar year.</i>
<input type="checkbox"/>	Hardship	Please contact the WAPA office at Info@wapa.org

Total Enclosed: \$ _____ *Note: The dues year is January-December. Dues are not prorated.*

Method of Payment: Check _____ Credit Card (Visa / MasterCard / Discover/American Express)

Card #	Expiration Date	Security Code
Name on Card		
Signature		

Who referred you? Please enter their name here:	Return this form and payment to: Wisconsin Academy of PAs N83 W13410 Leon Road Menomonee Falls, WI 53051 info@wapa.org (414) 253-8188
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