American Association of Physicians of Indian Origin

Executive Headquarters: 600 Enterprise Drive Suite 108, Oak Brook, IL 60523
Telephone: (630) 990-2277, Fax: (630) 990-2281
AAPI Tax ID: 38-2532505 www.aapiusa.org

AAPI Membership Application

First Name: ______________________ Last Name: ______________________ Middle Initial: ____

Address: ____ ☐ Home ☐ Office

City: ________________________ State: _________ Zip: _______________ Gender: ____________

Home Phone: _________________ Office Phone: ____________________ Fax: ________________

Email (*unique*): ____ Date of Birth: _____________

Med School: ________________________________ Start Year _________ End Year ____________

Residency Institution: _________________________ Start Year _________ End Year ____________

Fellowship Institution: ________________________ Start Year _________ End Year ____________

Primary Specialty: ____________________________ Secondary Specialty: ____________________

*** Training Level (Circle one):** ☐ Attending ☐ Young Physician ☐ Fellow ☐ Resident ☐ Medical Student ☐ Attending/GC BACKLOG

If Young Physician, please select which year you are in.) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

If Medical Student or Resident or Fellow - please select one:

- ☐ **Medical Student –** Anticipated year of completion ___________ *(Not eligible for Patron Membership)*
- ☐ **Resident –** Anticipated year of completion ___________ Specialty _______________________
- ☐ **Fellow –** Anticipated year of completion ___________ Specialty _______________________

***MEMBERSHIP CATEGORIES:**

- ☐ **~~$500 $250~~ $100 Patron (Life) Membership (Promotion till November 19, 2021)**
  (Attending Physicians, Young Physicians in their first 10 years of practice, Residents and Fellows only)
- ☐ **$100 Annual Membership for Attending Physicians**
- ☐ **$50 Annual Membership for Young Physicians (YPS)**
- ☐ **$0 Annual Membership for Medical Student/Resident/Fellow (MSRF)**

To Pay by Credit Card, please mail this application along with your Credit Card Information to:
AAPI Executive Office; 600 Enterprise Drive, Suite 108, Oak Brook, IL 60523 **or Fax it to: (630) 990-2281**
Payment shall be made by personal credit card, personal check or by employer check only.

PAYMENT INFO ☐ **Visa** ☐ **American Express** ☐ **Master Card** ☐ **Discover**

Credit Card Number: ____ Exp. Date: _______________ CVV: ________

Card Holder's Name: ________________________________ Signature: ___________________________________

Credit Card Billing Address (if different than above): ____

☐ I agree to pay the total amount according to USA card issuer agreement. All credit card transactions are processed in U.S. dollars and are subject to the current exchange rates.

To Pay by Check, please mail this application along with your check to:
American Association of Physicians of Indian Origin, 600 Enterprise Drive, Suite 108, Oak Brook, IL 60523

☐ The information provided in this application are true and correct. Filling this application doesn't entitle me to be a member of AAPI. I understand that the AAPI Membership Committee will review my information provided in this application. If found not eligible for AAPI membership, I acknowledge that the dues paid are **non-refundable**.
As a member of AAPI, I will abide by the **AAPI Bylaws and it's Articles of Incorporation)**

***Signature:** ____ **Date:** ____________________