



The American College of FOOT & ANKLE ORTHOPEDICS & MEDICINE

APPLICATION FOR MEMBERSHIP

(Please check appropriate box)

Fellow

Associate

Member

Resident

Name: _____

Position: _____ Clinic/Practice Name: _____

Office Street Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

E-mail: _____ Web Site: _____ Gender - M or F

(Please print clearly! We do most membership correspondence via e-mail.)

EDUCATION: List in chronological order all undergraduate, graduate, and professional schools attended, including podiatry college.

Name of School	City - State	Degree	Dates Attended

Membership in APMA is a requirement for ACFAOM membership: Are you a member in good standing of the American Podiatric Medical Association? Yes _____ No _____ APMA Member # _____

Date ABPM Certified: _____ or N/A Date ABPM Qualified: _____ or N/A Date of Birth: _____

I agree to abide by the Bylaws of the American College of Foot and Ankle Orthopedics and Medicine.

ACFAOM members may be listed in a database on its web site. This database is searchable by physicians and podiatrists for referrals and by prospective patients seeking a podiatrist. I hereby agree do not agree to have my name listed in ACFAOM's searchable database. For the right to have my name made available to prospective patients or other professional medical providers, I agree to hold the American College of Foot & Ankle Orthopedics & Medicine (ACFAOM) harmless from any and all liability, including court costs and attorney's fees, that may result from my name being made available to any individual. I understand that ACFAOM does not represent me in any way, nor does ACFAOM guarantee or represent that I will obtain assignments through this service.

ACFAOM contacts its members by e-mail to notify them of important issues, remind them of upcoming deadlines or provide them information regarding new products or services. I do do not grant permission to ACFAOM to contact me by e-mail.

I certify that the information in this application is true and accurate.

Signature: _____ Date: _____

Membership Fees:

Fellows - \$449

Associates - \$449

Members - \$349

Residents - Free

Charge to my: Check enclosed Credit Card: Amex MC VISA Dollar Amount: \$ _____

Name of Cardholder: _____ Signature: _____

Card Number: _____ Expiration Date: _____ CVV Code: _____

American College of Foot & Ankle Orthopedics & Medicine

5272 River Road, Suite 630 • Bethesda, MD 20816 • 301.718.6505 • Fax: 301.656.0989 • info@acfaom.org • www.acfaom.org

ACFAOM dues are not deductible as a charitable contribution for federal tax purposes, but may be deductible as a business expense. Consult your tax advisor.