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

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