AAPI Membership Application

Last Name:_____

First Name:_____Middle Initial:_____Gender:_____

Address:_____ Home ☐ Office ☐

City:_____State:_____Zip:_____

Office Phone:_____ Home Phone:_____

Fax:_____ E-mail:_____

College:_____

Year of Graduation:_____ Speciality:_____

Arizona Association of Physicians of Indian Origin

Is your spouse an MD? Y ☐ N ☐ If yes, complete the following:

Spouse's Name:_____
Last First Middle Initial

Address:_____

City:_____ State:_____ Zip:_____

E-mail:_____

Office Phone:_____ Fax:_____

College:_____ Year of Graduation:_____ Speciality:_____

MEMBERSHIP CATEGORIES:

☐ $500 Patron (Life) Membership ☐ $750 Joint Patron (Life) Membership (Husband & Wife)

☐ $50 Annual Membership ☐ $75 Joint Annual Membership

☐ Medical Student / Resident / Fellows - Dues Waived

PAYMENT INFO ☐ Cash ☐ Check

Signature:_____

Mail or Fax this application to: 2600 E. Southern Ave, Suite I-1, Tempe, Arizona 85282 Fax: 480-821-3806