AASPA

American Association of Surgical Physician Assistants

■ PO BOX 781688, Sebastian, FL 32978 ■ 772-388-0498
■ Fax 772-388-3457 ■ www.aaspa.com ■ Twitter@SurgeryPA
■ AASPA Federal Tax ID number: 63-0797410

*Name*_____
Last *First* *MI*

PLEASE PRINT CLEARLY

E-MAIL ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Preferred Mailing Address: ❒ *Home* ❒ *Business* ❒ ***New address change (If renewal)*** ❒ *Home* ❒ *Business*

Home Address: *Street:*_____ *Apt #:* _____

City: _____ *State:* _____*Zip Code:* _____ *Phone:* _____

Employer: *Business Name:* _____

*Street:*_____ *Suite #:* _____

City: _____ *State:* _____*Zip Code:* _____ *Work Phone:* _____

Surgical specialty: _____ AAPA Member ***Yes*** ❒ ***No*** ❒

Are you certified by NCCPA ❒**YES** ***NCCPA Certificate Number:*** _____***Exp. Date:***_____

❒ **NO** ***If you are a new Fellow but not NCCPA certified please attach a copy of your PA program certificate.***

1. ❒ **FELLOW $150.00 1 Year 2 Year $250.00** ❒ **NEW MEMBERSHIP** ❒ **RENEWAL**

❒ **RETIRED FELLOW $75.00*** ****Must be a Fellow member in good standing for the previously 3 years and submit a letter from your supervising physician and/or hospital that you're not currently working.***

❒ **ACTIVE/RETIRED MILITARY FELLOW $100.00*** ****Please submit your military discharge papers. If active, please submit your military email address.***

❒ **RESIDENT $80.00*** ****Please enclose a letter from program director documenting status.***

❒ **STUDENT $25.00** ***PA Program*** _____ ***Date of Graduation**_____

One time fee while a PA student until graduation (* Your application can not be processed without the Graduation Date)* MTH/YEAR

❒ **PRE-PA STUDENT DONATION $75.00**

2. Optional Donation ❒ **SUSAN & THOMAS LUSTY MEMORIAL STUDENT SCHOLARSHIP FUND:**
❒ **$15.00** ❒ **$25.00** ❒ **$50.00** ❒ **Other** _____
❒ **SURGICAL PA MARKETING FUND:**
❒ **$15.00** ❒ **$25.00** ❒ **$50.00** ❒ **Other** _____

3. Total Payment: Dues_____ ***Donations*** _____***Total $*** _____

4. ❒**Check *payable to AASPA*** ❒**CREDIT CARD** ❒VISA ❒ MASTER ❒ AMEX

C A R D N U M B E R ***EXP DATE*** ***CCV CODE***

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_____ _____
NAME AS IT APPEARS ON THE CREDIT CARD ***BILLING ADDRESS IF DIFFERENT THAN ABOVE***

✍ _____ *Date* _____

If you are paying by credit card you may forward the application to: FAX 772-388-3457
OR Scan form and email: theaaspa@aol.com OR ONLINE www.aaspa.com

Return application, and payment to: AASPA, PO BOX 781688, Sebastian, FL 32978