INDIVIDUAL ADVOCACY MEMBERSHIP

APPLICATION FORM

NAME: _____

ADDRESS: _____

LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____ EMPLOYER: _____

EMAIL ADDRESS: _____

SIGNATURE: _____ DATE: _____

$10
Member Annual Dues

$450
Non-Member Annual Dues

BENEFITS

Exclusive Events *Meetings, Panels, Receptions*

Subscriptions *The Monthly Dose, Washington Weekly Update, Journal of America's Physician Groups*

Discounts *Annual Meeting & Colloquium in Washington, D.C.*

Access *Advocacy Campaigns & Materials*

I AM *(check one)*

- ☐ A physician or an executive that is currently employed by (or who contracts with) a member organization.
- ☐ A physician or executive from a medical group, IPA or other organization that takes risk, or aspires to take risk.
- ☐ A researcher, professor, or student at a medical school, school of osteopathic medicine, school of public health, or other graduate healthcare or business degree program.
- ☐ Other: _____

INFORM

ADVOCATE

ENGAGE

America's Physician Groups staff will review Advocacy Membership applications and may request additional information as needed.
Applicants will be notified in writing regarding acceptance.

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