INDIVIDUAL MEMBERSHIP APPLICATION

CONTACT INFORMATION: PLEASE TYPE OR PRINT CLEARLY

Date of Application _____

Full Name _____

Professional Credentials (check all that apply)

☐ MD ☐ DO ☐ PhD ☐ MBA ☐ CPA ☐ Other _____ Date of Birth: ___ / ____ / _____

Company / Practice Name _____

Company Mailing Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____ Fax (_____) _____

Company Email Address _____

Alternate Mailing Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____ Fax (_____) _____

Alternate Email Address _____

(Please note that most of APF's communication with members takes place through email. By not specifying a work or personal email address, you may not receive all of the benefits and information provided through your membership.)

Preferences:

Mailing Address: ☐ Work ☐ Alternate

Email Address: ☐ Work ☐ Alternate

Would you be interested in:

APF Committee Work: ☐ Yes ☐ No Areas of Interest _____

Speaking Opportunities: ☐ Yes ☐ No Areas of Interest _____

I hereby grant permission to include my contact information in the following:

☐ Online membership directory ☐ Rented direct mailing list ☐ Rented direct email list

Please indicate how you found out about APF:

☐ APF Member: _____

☐ Exhibit at Conference: _____

☐ Industry Affiliate Partner: _____

☐ APF Website

☐ Related Association: _____

☐ Other Source: _____

APF Members Only Web Access: Provide your preferred password to access the Members Only section at www.apfconnect.org

_____ (at least 5 characters)

MEMBER INFORMATION:

Employer Information: Please select the best description of your practice

☐ Hospital Based Practice Only (non-academic)

☐ Independent Laboratory Only

☐ Academic Institution / University / Teaching Hospital Based Only

☐ Other (please specify) _____

☐ Governmental Institution Only

☐ Combined Hospital Based / Independent Lab

☐ Supplier / Vendor or Pathology Products or Services

In what other pathology and medical organizations do you currently hold membership? (check all that apply)

☐ ACLA ☐ ACLPS ☐ ADASP ☐ AMA ☐ APC / PRODS ☐ ASCP ☐ CAP

☐ CLMA ☐ HBMA ☐ HFMA ☐ IAP ☐ MGMA ☐ USCAP ☐ WASPALM

☐ State Medical / Pathology Society(s) _____ Other(s) _____

MEMBER CATEGORIES AND FEES: (check category of membership for which you are applying)

☐ **ACTIVE PATHOLOGIST*** – Licensed physicians who are certified by the American Board of Pathology or a Board of similar standing. ***Applicants must provide proof of certification from the American Board of Pathology when submitting their membership application.*** **$300**

Physician Applicants Only: Medical School Attended: _____ Dates Attended: __/__/__ to __/__/__

Location of Pathology Residency: _____ Dates of Residency: __/__/__ to __/__/__

☐ **ACTIVE PATHOLOGY PROFESSIONAL*** – Non-physicians in the management of active pathology practices, who have a college degree OR a minimum of 5 years experience in health care management. **$300**

☐ **AFFILIATE** – Individuals who do not qualify for principal membership, but who wish to further the objectives of the Foundation. This would include physicians not certified by the American Board of Pathology; pathology practice or laboratory employees; laboratory or practice managers, administrators, consultants or executives who do not qualify as Active Associate members. **$300**

☐ **JUNIOR** – Individuals who are qualified physicians and are actively training for careers in pathology as recognized by the American Board of Pathology or a Board of similar standing. ***Applicants must provide proof of residency when submitting their membership application.*** **Free**

☐ **EMERITUS** – Any member who is retired for more than 5 years from active pathology practice. ***New Emeritus Members should submit a letter of application to the APF Board of Directors to receive this consideration.*** **Free**

☐ **PATRON** – Any individual member who contributes $100 or more over regular member dues in a given year. **$400** (and up) Please indicate the other category of membership for which you qualify: _____

(* Indicates members that can vote or hold elected office within the Foundation)

4 WAYS TO JOIN APF!

PHONE
Call toll-free 877.993.9935
Monday–Friday
9:00 am- 5:00 pm ET

FAX
Fax your completed application to 312.541.4998

WEBSITE
Visit us at **www.apfconnect.org** and select "Membership"

MAIL
Return your complete application (both sides) with payment to:

APF
3462 Eagle Way
Chicago, IL 60678-1034

PLEASE COMPLETE BOTH SIDES OF THIS FORM

ACADEMIC INSTITUTION MEMBERSHIP APPLICATION:

Academic Institution Membership is available to all ACGME accredited pathology training programs. Membership is inclusive of the Department Administrator, and all interested full time faculty members, residents and fellows. Each program will designate two key contacts for the member organization (for example: Department Chair or Program Director, and Department Administrator). Each of the two key program contacts will be a voting member of the Foundation. Each member will be listed individually within the APF Membership Database under their designated membership category and have access to all the individual membership benefits provided by the Foundation. **$1,500 (1-30 members) • $2,500 (31-60 members)**

Name of Academic Institution: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

KEY CONTACTS:

Program Director or Department Chair: _____

Mailing Address: (if different from Institution) _____

City _____ State _____ Zip Code _____

Email Address: _____ Phone Number: _____

Password: _____ Member Type: Active Pathologist

Department Administrator (Responsible for maintaining Program's membership account): _____

Mailing Address: (if different from Institution) _____

City _____ State _____ Zip Code _____

Email Address: _____ Phone Number: _____

Password: _____ Member Type: Active Associate

PLEASE USE INSERT FOR ADDITIONAL APPLICANTS – YOU MAY INCLUDE UP TO 60 PER PROGRAM

INDUSTRY AFFILIATE MEMBERSHIP:

Companies that supply products and services to pathology practices. Membership is inclusive of a primary contact and two additional company contacts determined by the principal member. Companies holding this type of membership are listed in the APF Marketplace section of the website and are entitled to use all APF marketing and communications programs. Industry Affiliate companies will have early access for choosing conference booths and sponsorships and other benefits as determined by the APF Board of Directors. **$1,000**

Primary Member _____ Password _____

Email Address _____ Phone Number _____

Additional Member _____ Password _____

Email Address _____ Phone Number _____

Additional Member _____ Password _____

Email Address _____ Phone Number _____

Company Mailing Address _____

City _____ State _____ Zip Code _____

Please select the category the best describes your company:

☐ A vendor company that sells products or services to pathology practices (not a sole proprietor)

☐ A consulting firm or sole proprietor consultant

Are you interested in exhibiting at APF Conferences or Sponsorship of Events / Online Resources? ☐ Yes ☐ No

Company Information: What products or services does your company sell to pathology practices?

☐ Accounts Receivable ☐ Billing Services ☐ Billing Software ☐ Clearinghouse Services
☐ Coding Services ☐ Collections ☐ Computer Hardware ☐ Computer Software
☐ Computer Support ☐ Consulting Services: Specify area(s) _____
☐ CPA Services ☐ Credit Card Processing ☐ Document Imaging/ Management ☐ Financial / Lending
☐ Financial Management ☐ Laboratory Equipment / Supplies: Specify type(s) _____
☐ Insurance ☐ Investment Management ☐ Mailing Services ☐ Marketing
☐ Medical / Business Forms ☐ Office Supplies ☐ Personnel Management ☐ Practice Management Systems / Services
☐ Printing ☐ Phone Systems / Support ☐ Professional Staffing ☐ Publisher
☐ Training Services ☐ Website Development ☐ Other _____

Company Description: (provide a brief description of your company's products or services to be published in the APF Marketplace Directory)

_____

_____

_____

PAYMENT INFORMATION

Check Enclosed (payable to "APF") # _____ ☐ Personal ☐ Company

☐ Visa ☐ Mastercard ☐ AMEX Card # _____ CVV# _____ Exp. Date _____

Name on Card (please print) _____

Authorized Signature _____