



International Association
of Physicians in AIDS Care

Membership Application

GENERAL INFORMATION - Please clearly fill out ALL of the information below

First Name: _____ Middle Name: _____ Last Name: _____

MD PhD DO RN PA PharmD Other: _____

Affiliation: _____

Address: _____

City: _____ St/Province: _____ Zip/Postal Code: _____ Country: _____

Phone: _____ Fax: _____ E-mail: _____

Do you prefer to receive information via: E-mail or Fax?

MEMBERSHIP CATEGORIES - Please check the appropriate box. Please see reverse side for category benefits

Contributing Member USD\$200
Open to all individuals

AIDS Service Organization USD\$75
Organizations providing services to those affected by HIV/AIDS

Member USD\$165
Membership designated for MD, DO, PhD, PharmD

Student Member USD\$30
*Medical/Health Profession students;
must have three months remaining in respective programs*

Associate Member USD\$125
Membership designated for RN, NP, PA, LPN

Affiliate Member USD\$50
*Individuals not in the medical profession, but
who have a general interest in HIV/AIDS issues*

DEMOGRAPHIC INFORMATION

Specialty: Family Practice Adult Infectious Disease Obstetrics/Gynecology Pediatrics
 Internal Medicine Other _____

Primary employment affiliation: Federal Government University/Medical School Private/Group Practice Hospital/Clinic
 State/Local Government Pharma/Biotech Industry Other _____

Estimated number of HIV patients you treat each year: _____

Optional: Sex: F M Age: _____

PAYMENT INFORMATION

I have enclosed a check made payable to IAPAC - OR -

Please bill my: Master Card VISA American Express

Credit card number: _____

Name (as it appears on credit card): _____

Expiration date: _____ Credit card CCV2 indicator: _____

(3-4 digit # on the front or back of your card, after the account number)

RETURN TO

IAPAC, 123 W. Madison, Ste. 1400, Chicago, IL 60602-2501, USA - OR - Fax to: 1-(312) 795-4938 - OR - Join online at www.iapac.org