

# APPNA NEW JERSEY MEMBERSHIP APPLICATION

## APPLICANT INFORMATION (FOR INSTRUCTION SEE PAGE 2)

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Office Address:

City:	State:	ZIP Code:
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Office Phone	Office Fax	Email:
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Home Address:

City:	State:	ZIP Code:
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Home Phone	Home Fax	Email:
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Preferred Mailing Address: :  Office  Home Preferred Mode:  Email  Fax  Text Msg.  US Mail

Cell Phone:	Cell Phone 2:
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Documentary proof of NJ Residence :

## PROFESSIONAL INFORMATION

Medical College:	Year of Graduation:
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Primary Specialty:	Secondary Specialty:
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Institution:	Department:
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State of Licensure:	License #:	Expiry Date:
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Documentary proof of Medical License in USA :

## MEMBERSHIP ELIGIBLTY

Field of Work (Check one of the following):

Academics  Clinical Research  Healthcare Management  Public Health  Physician-in-Training

Others: *(please describe)* \_\_\_\_\_

## MEMBERSHIP CATEGORY AND PAYMENT (PLEASE CHOOSE THE CATEGORY THAT APPLIES)

Membership Category	Membership Duration	Fee	Amount Enclosed	
Lifetime Member	Lifetime	\$525.00	\$	
Annual Member	January 1 – December 31	\$35.00	\$	
Affiliate Member	January 1 – December 31	\$	\$	
Associate Member	January 1 – December 31	\$	\$	
Physician-in-Training	January 1 – December 31	<i>Dues exempted</i>		
Emeritus Member	January 1 – December 31	<i>Dues exempted</i>		
Student Member	January 1 – December 31	<i>Dues exempted</i>		

PAYMENT AMOUNT	\$	
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PAYMENT METHOD  CHECK  PAYPAL (ON-LINE REGISTRATION)

## COMMENTS

## DECLARATION

*I declare that above information is true, correct and complete to the best of my knowledge, and that I have read and fulfill all requirements to be an APPNA New Jersey member.*

Signature	Date
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## INSTRUCTIONS AND CONDITIONS

**Please fill out the form completely.**

**(USE COMMENTS SECTION FOR ANY ADDITIONAL INFORMATION YOU MAY WANT TO PROVIDE)**

### **Documentary proof of Medical License in USA (Required for 1<sup>st</sup> Time Registration )**

Please provide copy of USA State Medical License .

### **Documentary proof of NJ Residence: (Required for 1<sup>st</sup> Time APPNA-NJ Registration ).**

Please Provide One of the Following:

- Copy of New Jersey driver License.
- A recent Utility bill in your name with New Jersey address on it
- Your Bank statement or financial document with you name and New Jersey address on it.

### **MEMBERSHIP CATEGORY PROOF:**

*Documentary Proof: (all applicable documents must accompany the application form)*

- **Employee:** Letter from the employer confirming full-time paid position
- **Self-employed:** Copy of the Articles of Incorporation of a healthcare enterprise
- **Physician-in-Training:** Letter from the program director or copy of the contract
- **Note:** Physicians not meeting eligibility criteria mentioned above may apply for **Associate Membership** and enjoy all member privileges except voting in APPNA-NJ elections.

### **VOTING PRIVILEGES AND PRIVACY:**

**VOTING PRIVILEGE:** Applications are subject to a process of verification & certification.

**VOTER PRIVACY:** Members who desire to be put on No-Call/No-Fax list to avoid campaign relating communication should notify APPNA-NJ in the "Comments" section of the form.

### **THIRD PARTY PAYMENTS:**

**THIRD-PARTY PAYMENT:** APPNA-NJ does not accept membership fee from an individual or entity other than the applicant, applicant's spouse, children, siblings or employer.