



Missouri Academy of Physician Assistants
Membership Application
Membership year July 1 – June 30
www.moapa.org

Name: _____

Work Address: _____ Home Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Preferred Mailing Address Home _____ Work _____

E-mail Address: _____

Home Phone: _____

Work Phone: _____

Fax Number: _____

Practice Specialty: _____

NCCPA Certification #: _____ Program Attended: _____

Current AAPA Member: _____ Yes _____ No AAPA Membership Number: _____

I am applying for membership in the following category:

_____ Fellow; *PAs practicing* in the state and *AAPA members* - \$100/Year, July 1 to June 30

_____ Associate; *PAs practicing* in the state and *not AAPA members* (non-voting) - \$100/Year, July 1 to June 30

_____ Affiliate; *Non-PAs* wishing to be associated with MAPA (non-voting) - \$100/Year, July 1 to June 30

_____ Student; \$20/2Years, thru June of graduating year (Include a letter of verification from Program Director) **Graduation Date:** _____

Would you like for your name to be published in our annual membership directory? _____ Yes. _____ No.

MAPA has my permission to release this information to individuals interested in purchasing membership information. _____ Yes. _____ No.

I certify that the above information is complete and accurate, to the best of my knowledge. I understand that withholding information or giving false information may invalidate my membership and be just cause for expulsion from MAPA.

Signature _____ Date: _____

Please note: Membership dues to the Missouri Academy of Physician Assistants are *NOT* tax deductible.

Make check payable to **Missouri Academy of Physician Assistants** and mail to:

Missouri Academy of Physician Assistants
950 North Washington Street
Alexandria, VA 22314-1552

Contact us toll free with questions: **800/844-4902** or by e-mail at **mapa@aapa.org**