



Membership Application

Name: _____ Professional Designation: _____

Email: _____

Primary Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Fax: _____

Home Phone: _____ Cell Phone: _____

Are you an AAPA Member? Yes No If yes, AAPA Member Number: _____

Please select the membership type that applies to you.

Fellow: Fellow members are defined as Physician Assistants who are licensed in and residents of Alaska, and who are Fellow members of AAPA. All fellow member can vote and hold office.

Single Year \$100 Three Years \$270

Associate: Associate members are Physician Assistants or health care providers who do not meet the criteria for AKAPA Fellow membership. *50% active military discount available.

Single Year \$100 Three Years \$270

Student: Student members must currently be enrolled in an accredited PA training program and must be from, reside or intend to reside in the State of Alaska following graduation.

\$25 Expected date of graduation _____

(Student Membership will remain current until December 31st of the year of graduation)

Three year membership reflects a 10% discount. Membership is year to date.

Would you like to be contacted about serving on the board of directors or on a committee? Yes No

Signature _____

Date _____

Print and complete form and fax or mail to:

Pay by Credit Card

Alaska Academy of PAs
2804 West Northern Lights Blvd
Anchorage, AK 99517
Fax: 907-562-8641
Email: info@akapa.org

Name on Card: _____

Card Type: _____

Card Number: _____

Expiration Date: _____

Checks can be made out to;
Alaska Academy of Physician Assistants

Signature: _____