Residency Program Starter Package

Residency Program Name:_____

Program Address: _____

Program City, State, and Zip: _____

ACGME Number:_____ AOA Number:_____

Program Director Name: _____

Program Director Email:_____

Program Administrator Name:_____

Program Administrator Email:_____

Program Administrator Phone:_____

Number of Resident Positions:_____

Method of Payment

Check enclosed ☐ Make check payable to "Society of Teachers of Family Medicine"

Card Number:_____ Exp:_____

Card Holder's Name:_____ Card Type: ☐ Visa ☐ AMEX

Email Receipt to:_____ ☐ Mastercard ☐ Check

Mail: Mary Theobald
Society of Teachers of Family Medicine
11400 Tomahawk Creek Parkway, Suite 240
Leawood, KS 66211

Fax: 913.906.6096

Membership Enrollment

Member #1

Name:_____ Gender: ☐ M ☐ F DOB:____/____/_____

Title:_____

Email:_____ Degree(s):_____

Work Phone:_____ Cell Phone:_____

Institution:_____

Membership Type

- ☐ Physician
- ☐ Other Fam Med Educator
- ☐ Associate Member
- ☐ International Member
- ☐ Fellow Member
- ☐ Resident Member
- ☐ Student Member

What is your race/ethnicity?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black or African American
- ☐ Hispanic, Latino, or Spanish Origin
- ☐ White
- ☐ Multiracial
- ☐ Other
- ☐ I choose not to disclose

Professional Role? (Check all that apply)

- ☐ Behavioral/Social Science Specialist
- ☐ Coordinator/Admin Staff
- ☐ Department Chair
- ☐ Fellow
- ☐ Health Educator/Dietician
- ☐ Medical Student
- ☐ Medical Student Education Director/ Clerkship Director
- ☐ Medical Student Education Faculty
- ☐ Nurse Practitioner
- ☐ Nurse/Medical Assistant
- ☐ Pharmacist
- ☐ Physician Assistant
- ☐ Practicing Physician
- ☐ Researcher
- ☐ Residency Director
- ☐ Residency Faculty
- ☐ Resident
- ☐ Retired
- ☐ None of the above

Work Setting:

- ☐ I work for an Association
- ☐ I work in Private Practice
- ☐ I work for a Government Agency
- ☐ I do not work for an association, government agency or in private practice

Preferred Mailing Address ☐ Home ☐ Office

Line 1: _____

Line 2: _____

City: _____ State/Prov: _____

Country:_____ Zip Code:_____

Membership Enrollment

Member #2

Name:_____ Gender: ☐ M ☐ F DOB:____/____/_____

Title:_____

Email:_____ Degree(s):_____

Work Phone:_____ Cell Phone:_____

Institution:_____

Membership Type

- ☐ Physician
- ☐ Other Fam Med Educator
- ☐ Associate Member
- ☐ International Member
- ☐ Fellow Member
- ☐ Resident Member
- ☐ Student Member

What is your race/ethnicity?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black or African American
- ☐ Hispanic, Latino, or Spanish Origin
- ☐ White
- ☐ Multiracial
- ☐ Other
- ☐ I choose not to disclose

Professional Role? (Check all that apply)

- ☐ Behavioral/Social Science Specialist
- ☐ Coordinator/Admin Staff
- ☐ Department Chair
- ☐ Fellow
- ☐ Health Educator/Dietician
- ☐ Medical Student
- ☐ Medical Student Education Director/ Clerkship Director
- ☐ Medical Student Education Faculty
- ☐ Nurse Practitioner
- ☐ Nurse/Medical Assistant
- ☐ Pharmacist
- ☐ Physician Assistant
- ☐ Practicing Physician
- ☐ Researcher
- ☐ Residency Director
- ☐ Residency Faculty
- ☐ Resident
- ☐ Retired
- ☐ None of the above

Work Setting:

- ☐ I work for an Association
- ☐ I work in Private Practice
- ☐ I work for a Government Agency
- ☐ I do not work for an association, government agency or in private practice

Preferred Mailing Address ☐ Home ☐ Office

Line 1: _____

Line 2: _____

City: _____ State/Prov: _____

Country:_____ Zip Code:_____

Membership Enrollment

Member #3

Name:_____ Gender: ☐ M ☐ F DOB:____/____/_____

Title:_____

Email:_____ Degree(s):_____

Work Phone:_____ Cell Phone:_____

Institution:_____

Membership Type

- ☐ Physician
- ☐ Other Fam Med Educator
- ☐ Associate Member
- ☐ International Member
- ☐ Fellow Member
- ☐ Resident Member
- ☐ Student Member

What is your race/ethnicity?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black or African American
- ☐ Hispanic, Latino, or Spanish Origin
- ☐ White
- ☐ Multiracial
- ☐ Other
- ☐ I choose not to disclose

Professional Role? (Check all that apply)

- ☐ Behavioral/Social Science Specialist
- ☐ Coordinator/Admin Staff
- ☐ Department Chair
- ☐ Fellow
- ☐ Health Educator/Dietician
- ☐ Medical Student
- ☐ Medical Student Education Director/ Clerkship Director
- ☐ Medical Student Education Faculty
- ☐ Nurse Practitioner
- ☐ Nurse/Medical Assistant
- ☐ Pharmacist
- ☐ Physician Assistant
- ☐ Practicing Physician
- ☐ Researcher
- ☐ Residency Director
- ☐ Residency Faculty
- ☐ Resident
- ☐ Retired
- ☐ None of the above

Work Setting:

- ☐ I work for an Association
- ☐ I work in Private Practice
- ☐ I work for a Government Agency
- ☐ I do not work for an association, government agency or in private practice

Preferred Mailing Address ☐ Home ☐ Office

Line 1: _____

Line 2: _____

City: _____ State/Prov: _____

Country:_____ Zip Code:_____