



# Membership Application

## Member Information

Name: \_\_\_\_\_ Gender:  M  F  Other  Choose not to disclose

DOB: \_\_\_/\_\_\_/\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Degree(s): \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Institution: \_\_\_\_\_

One or both of my parents (or whoever raised me) graduated from college  Yes  No  Choose not to disclose

## Membership Type

- Physician — \$340
- Other Fam Med Educator — \$235
- Coordinator Member — \$160
- Associate Member — \$160
- International Member — \$160
- Fellow Member — \$125
- Resident Member — \$50
- Student Member — \$0

## Race (Check all that apply)

- American Indian or Alaska Native
- Asian
- Native Hawaiian/Other Pacific Islander
- Black or African American
- White
- I choose not to disclose

## Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino

## Professional Role (Check all that apply)

- Behavioral/Social Science Specialist
- Coordinator/Admin/Manager
- Dean/Associate Dean
- Department/Vice Chair
- DIO
- Fellow
- Health Educator/Dietician
- Medical Student
- Med. Student Education/Clerkship Dir.
- Med. Student Education Faculty
- Nurse Practitioner
- Nurse/Medical Assistant
- Pharmacist
- Physician Assistant
- Practicing Physician
- Researcher
- Residency Dir./Associate Dir.
- Residency Faculty
- Resident
- Retired
- Other

## Preferred Mailing Address Home Office

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Prov: \_\_\_\_\_

Country: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Method of Payment

Card Number: \_\_\_\_\_ Exp: \_\_\_\_\_ CVV: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_ Card Type:  Visa  AMEX

Email Receipt to: \_\_\_\_\_  Mastercard  Check

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

**Fax:** 913.906.6096 **Email:** seggers@stfm.org **Questions?** Contact Sarah Eggers at 913.800.5650