Association of Pakistani Physicians of North America
Ohio Chapter

Membership Application/ Membership Renewal
Database update Form 2019

Basic data

Member Name*: _____ _____ _____
First *Middle* *Last*

Spouse Name: _____ _____ _____
First *Middle* *Last*

Address*: _____ _____
Street address *Apt. #*

_____ _____ _____
City *State* *Zip Code*

Medical College of Graduation:_____
Graduation Year: _____
Academic Appointment: _____
Primary Specialty: _____
Secondary Specialty: _____
Practice: _____ Solo _____Group _____ Hospital

Family data

	Children First	**Last**	**Age**	**Gender**
1				
2				
3				
4				

Contact data

Email*:		**Preferred (Y/N)**
Phone (H)*:		
Phone (C):		
Phone (W):		
Fax:		

**** Required information***
Check the type of membership desired

	Life time Membership	US $250.00	
	Annual Membership**	US $ 50.00	
	Physicians -In – Training	Exempt	Dues exempt only with confirmation letter from program director or copy of contract

*****Annual dues are for Calendar year (January 1 – December 31)***

PAYMENT must be made by a check. Please do not send cash

Please make checks payable to APPNA Ohio Chapter and mail to:
P. O. Box 882, New Albany, OH 43054
(Xerox copies of this form will be accepted)

For office use

Check # _____ *Amount:* _____

Date received: _____ *Date Processed:* _____