

**Missouri Academy of Physician Assistants**  
**Membership Application**

(Please write or type all information legibly)

Last Name, First Name, MI: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Fax Number: (\_\_\_\_) \_\_\_\_\_

Practice Specialty: \_\_\_\_\_

eMail address: \_\_\_\_\_

NCCPA Certification #: \_\_\_\_\_

Program Attended: \_\_\_\_\_

Current AAPA Member: \_\_\_\_ Yes \_\_\_\_ No AAPA Membership #: \_\_\_\_\_

I am applying for membership in the following category:

- \_\_\_\_ Fellow \$100/year, July 1 to June 30 (Practicing PA)
- \_\_\_\_ Associate \$100/year, July 1 to June 30 (Not currently practicing as PA)
- \_\_\_\_ Affiliate \$100/year, July 1 to June 30 (Physician, Corporate Sponsor)
- \_\_\_\_ Student \$20/up to 2 years, expires on June 20th following graduation (Include a letter of verification from program director)

Would you like for your name to be published in our annual membership directory?

\_\_\_\_ Yes \_\_\_\_ No

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

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 may be cause for expulsion from MAPA.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

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

Missouri Academy of Physician Assistants  
Membership Services  
905 N Washington Street  
Alexandria, VA 22314-1552