



# DCAPA Membership Application

## Membership Categories (Please check one)

- Fellow Member - Annual Dues \$50:** A fellow member is a graduate of an accredited physician assistant program and is a fellow member of the AAPA. He/She shall have the privilege of the floor and be entitled to vote and hold office.
- Associate Member - Annual Dues \$50:** An Associate member is a graduate of an accredited physician assistant program but is not an AAPA member. Associated members can have the floor but may not vote or participate in issues relating to the AAPA such as voting for delegates, submitting resolutions, or representing chapters in the AAPA HOD.
- Student Member – Tenure of Program Dues \$10:** A physician assistant student who is currently enrolled in an ARC-PA accredited program. Student members shall be entitled to privileges of the floor but will not be entitled to vote or hold office except for the elected Student Representatives. There will be two Student Representatives one student from The George Washington University Physician Assistant Program and the other from the Howard University Physician Assistant Program. Each shall be elected by his or her peers and enjoy all rights and privileges including formal vote except in matters relating to the AAPA.
- Physician Member - Annual Dues \$50:** A US licensed physician. He/She shall have the privilege of the floor but shall not be entitled to vote or hold office
- Affiliate Member - Annual Dues \$50:** A person who is ineligible for any of the above categories and wishes to associate with the organization and is approved by the Board of Directors. Affiliate members shall be entitled to the privilege of the floor but shall not be entitled to vote or hold office.
- Honorary Members – Annual Dues \$50:** And other such members as may be recognized by the Board of Directors of the DCAPA.

Full Name \_\_\_\_\_ Title \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Current Employer: \_\_\_\_\_

Area of Specialty \_\_\_\_\_ Name of Training Program: \_\_\_\_\_

Year of Graduation: \_\_\_\_\_ NCCPA No: \_\_\_\_\_ State(s) licensed: DC MD VA Other: \_\_\_\_\_

### Additional Areas of Support: I would like to serve DCAPA in the following capacity:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Membership            | <input type="checkbox"/> Newsletter (Writing/Editing Articles) | <input type="checkbox"/> CME Planning     |
| <input type="checkbox"/> Leadership            | <input type="checkbox"/> PA Student Preceptor                  | <input type="checkbox"/> Public Relations |
| <input type="checkbox"/> Reimbursement         | <input type="checkbox"/> Finance                               | <input type="checkbox"/> Diversity        |
| <input type="checkbox"/> Speaker / Topic _____ |  | <input type="checkbox"/> Other _____      |

### Please include the following donation amount to the DCAPA Scholarship Fund in my Total:

- \$10.00     \$20.00     50.00     Other: \_\_\_\_\_

### Payment Options

Credit Card:  VISA     MasterCard     American Express     Check Enclosed (Payable to DCAPA)

Name on Card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

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

**Total Amount:** \_\_\_\_\_

### **If paying by check, please mail to:**

**DCAPA  
3950 Chain Bridge Road,  
Suite 12  
Fairfax, Virginia 22030**