NEW MEMBER APPLICATION

Please complete fully and carefully, checking all relevant boxes. Enclose check for appropriate dues amount, and please consider adding an additional donation to help replenish our treasury ($15 or more suggested).

Mail with your check to: CAPM, P.O. Box 8506 Redlands, CA 92375-1706

Date:_____

NAME (Print):_____
First **Middle** **Last**

PREFERRED E-MAIL ADDRESS:_____ Alt. e-mail:_____
E-mail address essential for communication

Dues Category: ❑Regular $40 ❑Retired $20 ❑Resident $10 ❑Medical student $5 ❑Extra donation $_____

Past Member? ❑ No ❑ Yes When? _____

Present Position:_____

Employer or Affiliation:_____

Practice of Preventive Medicine or one of its sub-specialities:

❑ Full-time ❑ Part-time ❑ Retired ❑ None currently

Please check preferred address and phone for contact below, but please complete all:

Work Address: ❑_____

Home Address: ❑_____

Phone: Work: ❑ ( )_____ Home: ❑ ( )_____ Cell: ❑ ( )_____

Please complete requested information and check all applicable boxes:

Medical School:_____ **Degree:**_____ **Grad. Year:**_____

Pub. Hlth. School:_____ Degree:_____ ❑ Earned Yr.:_____ ❑ Pending

❑ Residency Training:

Specialty #1:_____ Institution:_____ ❑ Completed ❑ In progress

Specialty #2:_____ Institution:_____ ❑ Completed ❑ In progress

❑ Academic Title and Institution:_____

Please check or enter current memberships in professional organizations:

❑ ACPM (❑ ACPM Fellow? May add to qualification for CAPM Fellow)

❑ Local Medical Society & CMA ❑ AMA ❑ APHA ❑ CLHO/HOAC

❑ Other (list):_____

Special Area(s) of Interest in Preventive Medicine:_____

Personal/Professional Info. of Interest (Spouse/Partner, Past Positions, Hobbies):_____

_____

❑ Board Certification: (ABPM or other required for Fellows)

Name of Board #1:_____ Yr.:_____ Number (if known):_____

Name of Board #2:_____ Yr.:_____ Number (if known):_____