American Academy of Functional Medicine

P.O. Box 825 Fairforest, SC 29336
Tel.: (864) 576-2983 Fax: 925-380-4944, Email: doctorls@faafm.org

Submit by Email

Print Form

Application for Membership

Please print or type all information below and return form with payment to the address, email or fax above.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Country: _____

Tel: (O)(____) _____ Fax:(____) _____ Home:(____) _____

e-mail (very important): _____ Alternate e-mail: _____

How did you hear about the AAFM? _____

Professional Data: For Physicians, Non-Physicians and Professional Students only:

EDUCATION:

Undergraduate College or University	City and State	Years of Attendance	Graduation Date	Degree

Graduate College or University	City and State	Years of Attendance	Graduation Date	Degree

Professional University/College	City and State	Years of Attendance	Graduation Date	Degree

Postgraduate Certifications	City and State	Years of Attendance	Graduation Date	Degree

PROFESSIONAL LICENSES:

Type of License: _____ State: _____ License No.: _____
Type of License: _____ State: _____ License No.: _____
Type of License: _____ State: _____ License No.: _____

MEMBERSHIP CATEGORIES:

Physician (DC, DMD/DDS, DO, DPM, FNP/DNP, MD, ND/NMD, OMD, PsyD/PhD)…….. $ 99.00
Associate (Non-Physician)…….. $ 49.00
Professional Student…..... $ 24.00
Corporate / Educational Institution (circle selection) ……$250.00, $500.00, $1000.00, $1500.00, $2000.00, $2500.00

I hereby attest to the accuracy of the foregoing information, and apply for membership in the American Academy of Functional Medicine. I understand that my application is subject to AAFM review and approval and that membership will include all the rights and privileges accorded thereto by the AAFM By Laws. By my signature below, I agree to support the mission, tenets and objectives of the AAFM, and understand that any attempt to detract, diminish or undermine the mission, tenets and objectives will be sufficient grounds for censorship and revocation of my membership. I hold harmless the AAFM for obtaining any necessary public information and I formally give consent for release of said information. I also understand that failure to remit dues will result in suspension of all rights and privileges and loss of membership.

Signature: _____ Date: _____

Payment Options: (Circle One) Visa Mastercard Discover
Check (Payable to AAFM) Credit Card #: ____/____/____/____
#_____ Amt._____ Authorized Amt._____ Exp.:_____
Cardholder Signature: _____ Sec Code _____

By submitting my credit card information, I authorize AAFM to charge my credit card for my annual membership dues.