

# AAWC Membership Application

To ensure a current and complete member and directory listing,  
you are **STRONGLY ENCOURAGED** to **JOIN ONLINE** at [www.aawconline.org](http://www.aawconline.org).

## Required Information:

Name: \_\_\_\_\_ Credentials Printed After Name (RN, MD, CWS, WOCN, etc): \_\_\_\_\_

Professional Category (Choose one: MD, DO, DPM, PA, RN, LPN, NP, PT, PTA, OT, Pharmacist, Nutrition, Other): \_\_\_\_\_

Employer: \_\_\_\_\_ Position (Required): \_\_\_\_\_ Education Level (Required): \_\_\_\_\_  
(PhD, MD, DO, DPM, Bachelors, Masters, No Academic Degree, etc)

**PLEASE CIRCLE ONE TO THE RIGHT** → I am listing (**HOME**) or (**WORK**) below as my preferred address.

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_ E-mail (required): \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work – Required. If none, list home or cell): \_\_\_\_\_ (Cell): \_\_\_\_\_

## Employment/Practice setting (required). If none, select last option, "Not Applicable":

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Hospital           | <input type="checkbox"/> Stand Alone Clinic or Center | <input type="checkbox"/> Home Health Care   |
| <input type="checkbox"/> Long Term Care     | <input type="checkbox"/> Private Office/Facility      | <input type="checkbox"/> University/College |
| <input type="checkbox"/> Corporate/Industry | <input type="checkbox"/> Other: _____                 | <input type="checkbox"/> Not Applicable     |

Did someone refer you? If so, who? You and your recruiter will be eligible for a free membership: \_\_\_\_\_

Please tell us where you received this application. (Please be specific). \_\_\_\_\_

## **Choose all you are purchasing today below. We offer Individual and Facility/Corporate Memberships.**

### 1. Individual Memberships:

#### Clinician/Individual:

**\$108.75/one year membership; Clinician Special until 4/30/12**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Clinician/Individual Trial Membership for 6 months: | <b>\$99/Six Months</b>            |
| <input type="checkbox"/> Student:  | <b>\$60/Annually</b>              |
| <input type="checkbox"/> Retiree:  | <b>\$60/Annually</b>              |
| <input type="checkbox"/> Patient/Lay-Caregiver:                              | <b>\$Free Lifetime Membership</b> |

## AND/OR

### This is a (CHECK ONE):

- |  |                       |
|--|-----------------------|
| <input type="checkbox"/> Clinic/Healthcare Facility: | <b>\$360/Annually</b> |
| <input type="checkbox"/> Corporation/Manufacturer:   | <b>\$360/Annually</b> |

Check here if your company is interested in becoming an AAWC Corporate Sponsor. Many benefits apply including participation in Corporate Advisory Panel meetings with members of the AAWC Board of Directors.

## **TOTAL**

**Membership Dues (from above):** \$ \_\_\_\_\_

AAWC Scholarship Fund \$ \_\_\_\_\_ (restricted to supporting scholarships)

AAWC General Fund \$ \_\_\_\_\_ (supports all other projects /programs)

**TOTAL DUE:** \$ \_\_\_\_\_

## **PAYMENT METHOD** (It is not necessary to fill out this portion if you are paying in person to an AAWC representative.)

- Cash (In person only)     Check/Money Order (Payable to "AAWC" in US Funds from US Bank)     Visa     MC     AMEX

Card#: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_

Send this form to: AAWC - 83 General Warren Blvd, Ste 100 - Malvern, PA 19355 or Fax: 610-560-0502

Questions: (866) AAWC-999 or 610-560-0484    [www.aawconline.org](http://www.aawconline.org)

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