P.O. BOX 323
SOUTHFIELD MI 48037
WWW.CAAHP-USA.ORG

2017 MEMBERSHIP APPLICATION

Renewal_____ or New Member(s)_____ (check one)

Name (1):_____

Name(2) (if applicable):_____

Degree (1): MD DO DDS RPH Pharm D PA RN NP Other: _____
(Circle One)

Degree (2): MD DO DDS RPH Pharm D PA RN NP Other: _____
(Circle One)

Do you have an active license? Yes / No

For students and residents, list year of graduation from school/residency: _____

Address:_____

City:_____ State:_____ Zip:_____

Telephone (cell):_____

Telephone (work):_____

Email:_____(Required)

Signature:_____

Membership Fees: (Please check one)

_____Active Member (must be fully licensed/registered) - $125
_____Active Member + Spouse - $225
_____Active Member + Sibling living in same household - $225
_____Active Married Members (2 people licensed/registered) - $225
_____Associate Member (Unlicensed health professional) - $100 per person
_____Students, Members in training (i.e. resident or fellow) – NO CHARGE

Amount paid $_____

(Make check payable to CAAHP and mail to PO Box 323, Southfield MI 48037)