P.O. BOX 251294
W. Bloomfield MI 48325
WWW.CAAHP-USA.ORG

2020 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)

Email:_____(Second Member)

Signature:_____

Membership Fees: (Please check one)

_____Active Member (Fully licensed/registered or Unlicensed health professional) - $125

_____Active Member + Spouse or Sibling living in same household - $250

_____Active Married Members (2 people licensed/registered) - $250

_____Students, Members in training (i.e. resident or fellow) – $25

Amount paid $_____

(Make check payable to CAAHP and mail to PO Box 251294, W. Bloomfield MI 48325)