



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

2022 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) - \$150

_____Active Member + Spouse or Sibling living in same household - \$300

_____Active Married Members (2 people licensed/registered) - \$300

_____Students, Members in training (i.e. resident or fellow) – \$50

Amount paid \$_____

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