2024 MEMBERSHIP APPLICATION

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

☐ Renewal or
☐ New Member(s)

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):_____

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)