FLORIDA PODIATRIC MEDICAL ASSOCIATION
MEDICINE & SURGERY OF THE FOOT, ANKLE & LOWER EXTREMITY

3375-F Capital Circle NE, Ste. 201
Tallahassee, FL 32308
PHONE: 850-224-4085
FAX: 850-681-0899
fpma.com

APPLICATION FOR MEMBERSHIP

I hereby apply for membership in the Florida Podiatric Medical Association (FPMA) and to the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulations of the FPMA and the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

Last Name **First** **Middle**

Birth Date / / **Preferred Name**

Gender M ☐ F ☐ **Hours practiced per week** Less than 20 ◯

21 to 39 ◯ 40 ◯ None ◯

Ethnic Group *(for demographic use only)*

Do not wish to report ☐
American Indian/Alaska Native ☐
Asian* ☐
Native Hawaiian or other Pacific Island ☐
Black or African-American ☐
White ☐
Spanish/Hispanic/Latino/Latina** ☐

*This category includes Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, Malaysian, Pakistani, or Vietnamese
**This category includes Cuban, Mexican, Mexican American, Chicano/a, Puerto Rican, South, or Central American

U.S. Citizen *Yes* ☐ *No* ☐ *Do not wish to report* ☐

Principal Office/ Residency Address

Select as mailing address ☐

Street

City

Zip

County

Telephone ( )

Fax ( )

Home Address Select as mailing address ☐

Street City

Zip County

Telephone ( ) Fax ( )

Cell *(required)* ( ) E-mail *(required)*

Office Administrator

Name Email

Telephone ( )

Second Office Address Select as mailing address ☐

Street City

Zip County

Fax ( )

Telephone ( )

Preferred means of communication Email ◯ Phone ◯ Fax ◯

EDUCATION

Undergraduate Degree

Year State Institution Degree

Graduate Degree

Year State Institution Degree

Podiatric Medical Degree

Year Institution

Postgraduate Education Yes *(if yes, complete)* ◯ No ◯

Preceptorship Fellowship Residency

Program type (PMSR, PM&SR36, etc.)

Begin Date Institution Completion Date

MILITARY

Military Service

USA ☐ USAF ☐ USN ☐ USMC ☐ USCG ☐ Other

Date entered Date separated Current Rank

Reserves Y ◯ N ◯ *if yes, branch of service*

PROFESSIONAL LICENSURE

National Provider Identifier (NPI) Number

Podiatric Medical Licenses

Year	State	Number
Year	State	Number
Year	State	Number
Year	State	Number
Year	State	Number
Year	State	Number

Have you ever had a license to practice podiatric medicine suspended, denied, or revoked by any licensure authority?

◯ Yes *(If yes, please explain on a separate sheet)* ◯ No

Are you currently, or have you ever been, on probation, suspension, or investigation by any licensure, authority, state, or federal agency?

◯ Yes *(If yes, please explain on a separate sheet)* ◯ No

PODIATRIC MEDICAL PRACTICE

Original Practice Start Date

Month Day Year

APMA RECOGNIZED ORGANIZATIONS

(Check only those in which you have certification/membership)

Board Certification *If you are interested in learning about qualification and certification in these organizations, visit www.apma.org/certifyingboards*

- ☐ American Board of Foot & Ankle Surgery (formerly American Board of Podiatric Surgery)
- ☐ American Board of Podiatric Medicine (formerly American Board of Podiatric Orthopedics Primary Podiatric Medicine

Affiliated Membership *If you are interested in learning more about membership in these organizations, visit www.apma.org/affiliated*

☐ AAHP	American Association of Hospital and Healthcare Podiatrists
☐ AAPPM	American Academy of Podiatric Practice Management
☐ AAPSM	American Academy of Podiatric Sports Medicine
☐ AAWP	American Association of Women Podiatrists
☐ ACFAOM	American College of Foot and Ankle Orthopedics and Medicine
☐ ACFAP	American College of Foot and Ankle Pediatrics
☐ AENS	Association of Extremity Nerve Surgeons
☐ APMWA	Americans Podiatric Medical Writers' Association
☐ ASPD	American Society of Podiatric Dermatology
☐ ASPM	American Society of Podiatric Medicine
☐ ASPS	American Society of Podiatric Surgeons

PREVIOUS MEMBER OF THE FPMA

◯ Yes *(if yes, complete)* ◯ No

Dates

If previous member of other component association, state here

Previous member of any APMA/FPMA affiliated association? ◯ Yes ◯ No

If yes, state the association

Dates

SIGNATURE / INSTRUCTIONS

Please be aware that you may be required to provide additional documentation (copy of all state licenses, business card, sample of stationery, etc.) to the FPMA.

I understand that dual membership (FPMA and APMA) is required to be a member in good standing. I agree not to represent myself as a member of the FPMA or the APMA, if for any reason, I cease to be a member in good standing. I also understand that a portion of my annual dues is in payment for a one-year subscription for the ***APMA NEWS*** and for the ***Journal of the American Podiatric Medical Association*****.** I agree that incomplete or false information may be grounds for denial or termination of membership.

FPMA dues are not deductible as a charitable contribution for federal tax purposes but may be deductible as a business expense.

Applicant Signature: , DPM Date

For FPMA Use Only

Date completed application received

Member category

Date application was considered

Action Taken Approved Denied

APMA

Dues amount

Member Number

Date received

Elect Date