ASSOCIATION OF PROFESSORS OF DERMATOLOGY
MEMBERSHIP DUES RENEWAL

1: MEMBER INFORMATION

Name: __________________________________________ Degree(s) __________________________________

Institution: ______________________________________________________________________________________

Address: __________________________________________________________________________________________

City: ______________________________ State: __________ Zip Code: ______________

Email*: __________________________________________________________ Telephone: ___________________________

*All Association related correspondence, including receipts will be forward to this email address

Renewals are based on a calendar year

2: DEPARTMENTAL POSITION

_____ Department Chair/Division Chief $300.00 _____ Academic Dermatologists $100.00

_____ Dermatologic Surgery Division Head $250.00 _____ Doctor of Osteopathic Medicine $100.00

_____ Residency & Fellowship Program Directors $250.00 _____ Administrator/Coordinator $100.00

3: AFFILIATION: CHECK ALL THAT APPLY

_____ Department Chair __________ Dermatopathologist __________ Medical Dermatologist

_____ Division Chief ___________ Pediatric Dermatologist __________ Hospitalist

_____ Dermatologic Surgery Division Leader __________ Residency Program Director __________ Osteopathic Medicine

_____ Dermatologic Surgeon __________ Fellowship Director __________ Administrator/Coordinator

4: ANNUAL MEMBERSHIP DUES PAYMENT METHOD AND INFORMATION

CHECK: Check or Money Order must be United States Currency and Drawn from a United States Bank

Checks Payable to the “Association of Professors of Dermatology”

CREDIT CARD: Credit Card Information _______ American Express _______ Master Card _______ Visa

Total Amount Authorized for Annual Membership Dues $______________

Name on Card (please print) __________________________________________

Card Number ______________________________________________________

Expiration Date: __________________________ CVV 3/4 digit security code: __________________________

Signature: _________________________________________________________

5: THIS COMPLETED FORM WITH PAYMENT CAN BE SUBMITTED VIA ONE OF THE SUGGESTED METHODS

Mail Association Management Executives, Inc., 6134 Poplar Bluff Circle, Suite 101, Norcross, GA 30092

Fax 305.422.3327

Email maryann@theassociationcompany.com