PLEASE PRINT

Name____
First Middle Last Name Suffix/Credentials

Date of Birth_______________________________ Gender: ☐ M ☐ F
(MM/DD/YR)

Preferred Contact Via: ☐ Mail ☐ Email ☐ Fax

Telephone (Office)____

Fax (Office)____

E-Mail ____

☐ By checking this box I am requesting that information not be emailed or faxed to me.

Address: ☐ Home ☐ Business

Street:____Apt#:__________________________

City/State/Zip:____

☐ Use as Primary Mailing Address
☐ Use as Billing Address
☐ Use as Newsletter Address
☐ Use as Online Directory Address

AMA Member: ☐ Yes ☐ No

Membership Category & Dues (Please check one):

(Dues amounts listed are as of January 1, 2009)

☐ Active Category: Physicians.............................$375

(Please check one): ☐ Adult ☐ Pediatric

☐ Associate Category: Fellows (in training)..........$0

☐ Physician Assistant....................$275

☐ Practice Manager...$275

☐ Advanced Practice Nurse..........$275

Membership dues must be submitted with the membership application. RPA will process payment after the application is approved. Individuals may join at any time of the year and membership dues will be prorated through the end of the year (December 31st). Prorated amounts are calculated by dividing the amounts listed above by 12 months.

Nephrologist/Fellow

Education

Medical School_________________________________ Year of Graduation__________

Fellowships____
Hospital

City State Years Attended (ie 99-01)

Hospital

City State Years Attended (ie 99-01)

If applying for Associate membership:

Name of current training program facility and expected completion date

Certification

Specialty Board Certification (ABIM): ☐ Yes-Year_________ ☐ No

Nephrology Board Certification: ☐ Yes-Year_________ ☐ No

Licensure Information

License #____ State________

Practice Manager/Advanced Practice Nurse/Physician Assistants ONLY

Professional Reference

All applicants must list a professional reference who is an RPA nephrologist member employed by the same practice group as the appplicant.

Name____
First Middle Last Name

Street Address

City State Zip

Telephone

I hereby declare the information provided in this application is complete and true to the best of my knowledge.

Signature of Applicant Date

Payment

Please Check One

☐ Check enclosed (make payable to RPA) Check #: ___________

☐ Charge to: ☐ VISA ☐ MasterCard ☐ Amex ☐ Discover

Account # Expiration Date

Name on Card Signature

Please mail or fax to:

Renal Physicians Association, 1700 Rockville Pike,
Suite 220, Rockville MD 20852-9485
Fax: 301-468-3511

For RPA Use: Date Received____

Action: ☐ Approved ☐ Denied

Officer Signature____ Date______________________

WEB