



Special Group Application For Fellows (Trainees)

AAPM Trainee Membership

Trainee members must be enrolled and in good standing in a fellowship program in an institution within the United States approved by the American Board of Pain Medicine, the Accreditation Council on Graduate Medical Education, or the American Osteopathic Association. Trainee members may not vote or serve as officers or directors, but may serve and vote on committees. Trainee members shall be required to pay a nominal annual dues rate of \$50.

Trainees can join [online](#) or with a group application that can be submitted with payment.

Name _____ Degree _____
 Home Address _____ City _____
 State _____ Zip Code _____ Home E-mail _____
 Phone (home cell) _____ Fax (home office) _____
 Medical License: State ____ Number _____ Anticipated Graduation Date _____

Name _____ Degree _____
 Home Address _____ City _____
 State _____ Zip Code _____ Home E-mail _____
 Phone (home cell) _____ Fax (home office) _____
 Medical License: State ____ Number _____ Anticipated Graduation Date _____

Name _____ Degree _____
 Home Address _____ City _____
 State _____ Zip Code _____ Home E-mail _____
 Phone (home cell) _____ Fax (home office) _____
 Medical License: State ____ Number _____ Anticipated Graduation Date _____

Name _____ Degree _____
 Home Address _____ City _____
 State _____ Zip Code _____ Home E-mail _____
 Phone (home cell) _____ Fax (home office) _____
 Medical License: State ____ Number _____ Anticipated Graduation Date _____

Name _____	Degree _____
Home Address _____	City _____
State _____ Zip Code _____	Home E-mail _____
Phone (home cell) _____	Fax (home office) _____
Medical License: State _____ Number _____	Anticipated Graduation Date _____

Name _____	Degree _____
Home Address _____	City _____
State _____ Zip Code _____	Home E-mail _____
Phone (home cell) _____	Fax (home office) _____
Medical License: State _____ Number _____	Anticipated Graduation Date _____

Name _____	Degree _____
Home Address _____	City _____
State _____ Zip Code _____	Home E-mail _____
Phone (home cell) _____	Fax (home office) _____
Medical License: State _____ Number _____	Anticipated Graduation Date _____

Total dues	
_____ Number of Fellows (page 1)	Dues: _____
_____ Number of Fellows (page 2)	Dues: _____
_____ Total number of Fellows	Total dues: _____

Method of payment				
Check (made payable to AAPM)	MasterCard	VISA	Discover	AMEX
Account Number _____	Expiration Date _____			
Signature _____	Date _____			
(If you have a PDF-compatible e-signature, please use it above. If not, typing your name in the field above will constitute your e-signature.)				

Return completed application to: Mail: American Academy of Pain Medicine
P.O. Box 3781
Oakbrook, IL 60522 Fax: (847) 375-6477