

Yes, I will Join RPA!

Yes, We will Join RPA!

PLEASE PRINT

Name _____
First Middle Last Name Suffix/Credentials

Gender: M F

Telephone (Office) _____

Fax (Office) _____

E-Mail _____
(Email address that you desire RPA to use to send information.)

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

MAILING ADDRESS

Street: _____ Suite/Apt#: _____

City/State/Zip: _____

Membership Category & Dues:

(Dues amounts listed are as of January 1, 2011)

1st Applicant Name (must be a physician) _____ \$375

(Please check member type)

Practice Manager Advanced Practice Nurse Physician Assistant Other _____

2nd Applicant Name _____ 138.00

Practice Manager Advanced Practice Nurse Physician Assistant Other _____

3rd Applicant Name _____ 138.00

Practice Manager Advanced Practice Nurse Physician Assistant Other _____

4th Applicant Name _____ 138.00

Practice Manager Advanced Practice Nurse Physician Assistant Other _____

5th Applicant Name _____ 138.00

If you would like to or need to add additional team members (practice manager, advanced practice nurse, physician assistant, other, not physicians), use the reverse side to list names, category and payment. Applicants must be from the same practice. No Exceptions! All memberships/payments must be received at the same time on the same application. May not be used on a previous membership.

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.

CERTIFICATION AND CREDENTIALS

Applicant Name	ABIM (Circle One)	Nephrology Board Certified (Circle One)	License #	License State	Credentials
	Y or N	Y or N			

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

Signature of Physician 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

List additional names in this area (list full name, category and payment)

For RPA Use: Date Received _____

Action: Approved Denied

Officer Signature _____ Date _____