Membership Application

Member Information
Name:_________________________________ Gender: □ M  □ F  □ Other  □ Choose not to disclose
DOB:___/___/____  Title:__________________________________________________________
Email:_________________________________________ Degree(s):_____________________________________
Work Phone:_________________________ Cell Phone:____________________________________________
Institution:_______________________________________________________________________________

One or both of my parents (or whoever raised me) graduated from college □ Yes  □ No  □ Choose not to disclose

Membership Type
□ Physician — $340
□ Other Fam Med Educator — $235
□ Coordinator Member — $160
□ Associate Member — $160
□ International Member — $160
□ Fellow Member — $125
□ Resident Member — $50
□ Student Member — $0

Race (Check all that apply)
□ American Indian or Alaska Native
□ Asian
□ Native Hawaiian/Other Pacific Islander
□ Black or African American
□ White
□ I choose not to disclose

Ethnicity
□ Hispanic or Latino
□ Not Hispanic or Latino

Professional Role (Check all that apply)
□ Behavioral/Social Science Specialist
□ Coordinator/Admin/Manager
□ Dean/Associate Dean
□ Department/Vice Chair
□ DIO
□ Fellow
□ Health Educator/Dietician
□ Medical Student
□ Med. Student Education/Clerkship Dir.
□ Med. Student Education Faculty
□ Nurse Practitioner
□ Nurse/Medical Assistant
□ Pharmacist
□ Physician Assistant
□ Practicing Physician
□ Researcher
□ Residency Dir./Associate Dir.
□ Residency Faculty
□ Resident
□ Retired
□ Other

Preferred Mailing Address  □ Home  □ Office
Address:______________________________________________________________________________________
City:_________________________________________________ State/Prov: __________________________
Country:_________________________________________ Zip Code:___________________________

Method of Payment
Card Number:_________________________________________ Exp:___________________________
Card Holder’s Name:_________________________________________ Card Type: □ Visa  □ AMEX
Email Receipt to:_________________________________________ □ Mastercard  □ Check

Mail: Society of Teachers of Family Medicine, 11400 Tomahawk Creek Parkway, Suite 240, Leawood, KS 66211
Fax: 913.906.6096  Email: seggers@stfm.org  Questions? Contact Sarah Eggers at 913.800.5650

Society of Teachers of Family Medicine