



teach & transform

2023 Membership Application

Member Information

Name: _____ Gender: M F Other Choose Not to Disclose

Title: _____ DOB: ___/___/___

Email: _____ Degree(s): _____

Work Phone: _____ Cell Phone: _____ Opt-in for Text Messaging

Institution: _____

One or Both of My Parents (or Whoever Raised Me) Graduated From College Yes No Choose Not to Disclose

Membership Type

- Physician — \$375
- Other Family Medicine Educator — \$255
- Associate Member — \$170
- Coordinator — \$170
- International Member — \$170
- Fellow Member — \$130
- Resident Member — \$50
- Student Member — FREE

Race (Check All That Apply)

- American Indian or Alaska Native
- Asian
- Native Hawaiian/Other Pacific Islander
- Black or African American
- White
- Choose Not to Disclose

Ethnicity

- Hispanic, Latino
- Not Hispanic or Latino

Professional Role? (Check all that apply)

- Behavioral/Social Science Specialist
- Coordinator/Administrative Staff
- Department Chair
- Fellow
- Health Educator/Dietician
- Medical Student
- Anticipated Graduation Date _____
- Medical Student Education Director/
Clerkship Director
- Medical Student Education Faculty
- Nurse Practitioner
- Nurse/Medical Assistant
- Pharmacist
- Physician Assistant
- Practicing Physician
- Researcher
- Residency Director
- Residency Faculty
- Resident
- Anticipated Graduation Date _____
- Retired
- None of the Above

Preferred Mailing Address Home Office

Line 1: _____

Line 2: _____

City: _____ State/Province: _____

Country: _____ Zip Code: _____

Method of Payment

Card Number: _____ Exp: _____ CVV: _____

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:** stfmoffice@stfm.org **Questions?** Contact STFM at (800) 274-7928