STFM SOCIETY OF TEACHERS OF FAMILY MEDICINE teach & transform

2027 Membership Application

Member Information

Name:_____ Gender: ☐ Female/Woman ☐ Male/Man

☐ Genderqueer/Gender non-conforming ☐ Non-binary ☐ Prefer to self describe ☐ 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 — $410
☐ Other Family Medicine Educator — $275
☐ Associate Member — $180
☐ Coordinator — $180
☐ International Member — $180
☐ Fellow Member — $135
☐ Resident Member —$60
☐ 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/Providence:_____

Country:_____ Zip Code:_____

Method of Payment

Card Number:_____ Exp:_____ CVV:_____

Card Holder's Name:_____ Card Type: ☐ Visa ☐ AMEX ☐ Mastercard ☐ Check

Email Receipt to:_____

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