# AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS

## APPLICATION FOR MEMBERSHIP

DATE: _____

Name: _____ Medical Degree: _____
*First* *Middle* *First Last* *Second Last*

Year of Birth: _____ ❑ Male ❑ Female Billing Contact: _____

Office Address (*Listed in Directory*): _____

_____

City: _____ State: _____ Zip: _____ Country: _____

Office Phone: ( ) _____ Office Fax: ( ) _____ Cell Phone: ( ) _____

Home Address: _____

_____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: ( ) _____ Home Fax: ( ) _____ Preferred Mailing Address: ❑ Office OR ❑ Home

Email address: _____ Spouse name: _____

Your e-mail address will be shared with your local AACE Chapter for the purpose of receiving Chapter communication from the president or their designee. If you do not wish for your chapter to have access to your e-mail address, you must opt out by checking the box. ❑ Opt Out

## ABOUT YOUR PRACTICE

% of time spent in clinical practice: _____

### TYPE OF PRACTICE:

❑ Multi Specialty Group
❑ Single Specialty Group
❑ Solo Practice
❑ Partnership Practice
❑ Group Model HMO
❑ Government (VA, military, public health)
❑ Faculty, University
❑ Industry
❑ Hospital Based
❑ Retired
❑ Research
❑ Other _____

Does your practice consist of 50% or more:

❑ General Endocrinology and Metabolism
❑ Diabetes
❑ Surgical Endocrinology
❑ Reproductive Endocrinology
❑ Pediatric Endocrinology
❑ Other _____

## TYPE OF MEMBERSHIP *(see reverse side for definitions)*

❑ Active Domestic ❑ Retired ❑ International ❑ Associate (Fellow-in-Training) ❑ Affiliate (Resident in Internal Medicine or Pediatrics)

## EDUCATION AND TRAINING

College: _____ Degree: _____ Year Obtained: _____

Medical School: _____ Degree: _____ Year Obtained: _____

Internship / Residency: _____ ME #: _____

Approved Endocrinology Fellowship Program: _____

Endocrinology Fellowship Completion Date: _____ Duration: _____

Postgraduate Training: _____

Present Medical School / University Affiliations / Appointments: _____

Medical Licensure: Year Received: _____ License #: _____ State or Country: _____

## BOARD CERTIFICATIONS *(Please attach a copy of certificate from each Board listed)*

| | |
|---|---|
| Board: _____ | Date Certified: _____ |
| Board: _____ | Date Certified: _____ |

| FOR OFFICE USE: | Member #: | Publications: EP TFM No |
|---|---|---|

## AREAS OF CLINICAL INTEREST *(Please select five from the following list)*

*The following information is necessary for our affiliation with other organizations and will not be utilized in determining your eligibility for membership.*

- ❑ Adrenal Disorders
- ❑ Cancer
- ❑ Diabetes Mellitus
- ❑ Disease of Pregnancy
- ❑ Ectopic Endocrine Syndromes
- ❑ Gender Dysphoria
- ❑ General Endocrinology and Metabolism
- ❑ Geriatrics
- ❑ Graves Disease
- ❑ Growth Disorders
- ❑ Hypertension
- ❑ Lipid Disorders
- ❑ Menopause
- ❑ Metabolic Bone Disorders
- ❑ Neurosurgery
- ❑ Nuclear Medicine
- ❑ Nutrition
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Other
- ❑ Parathyroid Disorders
- ❑ PCOS
- ❑ Pediatrics
- ❑ Pituitary Disorders
- ❑ Reproductive
- ❑ Surgery
- ❑ Thyroid Dysfunction

## ARE YOU A MEMBER OF *(Please select from the following list)*

- ❑ American Association of Endocrine Surgeons
- ❑ American College of Physicians Association
- ❑ American Diabetes Association
- ❑ American Medical Association
- ❑ American Thyroid Association
- ❑ European Association for the Study of Diabetes
- ❑ European Society of Endocrinology
- ❑ Pediatric Endocrine Society
- ❑ Sociedad Mexicana de Nutrición y Endocrinología
- ❑ The Endocrine Society

*Please list any others:*

_____

## MEMBERSHIP CATEGORIES

**ACTIVE:** Any physician (MD, DO, or foreign equivalent) licensed to practice medicine in the United States who is engaged in the treatment of patients with endocrine diseases, involved in research activities relating to endocrine diseases, or involved in educational activities relating to endocrine diseases and/or diabetes mellitus is eligible to apply for memebership.

**INTERNATIONAL:** Physicians (MD, DO, or foreign equivalent) who are not residing in the United States of America, its territories or commonwealths; and have training or experience in the treatment of patients with endocrine diseases and/or diabetes mellitus.

**ASSOCIATE MEMBERSHIP:** Those physicians who are enrolled in postgraduate training in endocrinology and/or diabetes mellitus are eligible for associate membership.◆

**AFFILIATE MEMBERSHIP (RESIDENTS/MEDICAL STUDENTS):** Those physicians who are enrolled in a postgraduate residency training program in Internal Medicine or Pediatrics or Student enrolled in a medical school accredited by the Association of American Medical Colleges.◆

## MEMBERSHIP DUES

| | |
|---|---|
| **ACTIVE** | $295 |
| Application Fee | $75 |
| **Total for Active** | **$370** |
| **INTERNATIONAL** | |
| *Option 1 | $75 |
| **Option 2 | $295 |
| ***Option 3 | $325 |
| Application Fee | $75 |
| **Total for International** | **VARIED** |
| **RETIRED** | **$125** |
| Application Fee | $75 |
| **Total for Retired** | **$200** |
| **ASSOCIATE** (Fellow-in-Training) | *Complimentary* |
| **AFFILIATE** (Resident in Internal Medicine or Pediatrics) | *Complimentary* |

◆ ***For ASSOCIATE and AFFILIATE memberships a letter from the Fellowship or Resident Program Director or Medical School Official verifying status, starting and ending date must accompany application.***

* *Option 1 includes online only access to publications.*

** *Option 2 includes a subscription to Endocrine Practice and online-only access to The First Messenger.*

*** *Option 3 includes subscriptions to both publications*

Method of Payment: ❑ Cash ❑ Check ❑ MasterCard ❑ Visa ❑ American Express ❑ Discover

Name of Card Holder: _____ Amount: $ _____

Card Number: _____ Expiration Date: _____

Signature: _____ Billing Address: _____

City: _____ State: _____ Zip: _____ Country: _____

**For your protection, the American Association of Clinical Endocrinologists does not accept and will not process credit card information provided via email. Please mail or fax this form to our secured fax line (904)404-4229**

## REFERRED TO AACE BY

❑ Current AACE Member (Name): _____

❑ Publication (i.e., *Endocrine Practice*, *The First Messenger*): _____

❑ Meeting/Convention (Location/Dates): _____

❑ Other: _____

*Please return your application and payment or fellowship letter to:* AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS
245 RIVERSIDE AVENUE, SUITE 200 • JACKSONVILLE, FL 32202 • FAX: (904) 404-4229 • WWW.AACE.COM