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 — $350
□ Other Fam Med Educator — $240
□ 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
Street Address: ___________________________________________ Suite/Apt. # ___________________________
City: ___________________________________________ State/Prov: ___________________________
Country: ___________________________________________ Zip Code:____________________________

Method of Payment
Card Number: ___________________________________________ Exp:_________________ CVV:____________
Card Holder’s Name: ___________________________________________ Card Type: □ Visa □ AMEX
□ Mastercard □ Check
Billing Address: ___________________________________________ Email Receipt to: ___________________________

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