STFM SOCIETY OF TEACHERS OF FAMILY MEDICINE teach & transform

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

Billing Address: _____ ☐ 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