2021 Membership Application

STFM SOCIETY OF TEACHERS OF FAMILY MEDICINE teach & transform

Member Information

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

Title:_____ DOB:___/___/___

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 — $360
- ☐ Other Fam Med Educator — $245
- ☐ Associate Member — $165
- ☐ Coordinator — $165
- ☐ International Member — $165
- ☐ 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
- ☐ Choose Not to Disclose

Ethnicity

- ☐ Hispanic, Latino
- ☐ Not Hispanic or Latino

Professional Role? (Check all that apply)

- ☐ Behavioral/Social Science Specialist
- ☐ Coordinator/Admin 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/Prov:_____

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