teach & transform

2025 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 — $395
☐ Other Family Medicine Educator — $265
☐ Associate Member — $175
☐ Coordinator — $175
☐ International Member — $175
☐ Fellow Member — $130
☐ 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