



NEW MEMBER APPLICATION

Please complete fully and carefully, checking all relevant boxes. Enclose check for appropriate dues amount.
Mail to: CAPM, P.O. Box 8506 Redlands, CA 92375-1706

Date: _____

NAME (Print): _____
Last First Middle

PREFERRED E-MAIL ADDRESS: _____ Alt. e-mail: _____
E-mail address essential for communication

Dues Category: Regular \$35 Retired \$15 Resident \$10 Medical student \$5

Past Member? No Yes When? _____

Present Position: _____

Employer or Affiliation: _____

Practice of Preventive Medicine or one of its sub-specialities:

Full-time Part-time Retired None currently

(Check preferred address and phone for contact but please complete all)

Work Address: _____

Home Address: _____

Phone: Work: () _____ Home: () _____ Cell: () _____

Medical School: _____ Degree: _____ Grad. Year: _____

Pub. Hlth. School: _____ Degree: _____ Earned Yr.: _____ Pending

Please check if applicable and complete requested information:

Residency Training:
Specialty #1: _____ Institution: _____ Completed In progress

Specialty #2: _____ Institution: _____ Completed In progress

Academic Title and Institution: _____

Please check or enter current memberships in professional organizations:

ACPM (ACPM Fellow? May add to qualification for CAPM Fellow)

Local Medical Society & CMA AMA APHA CLHO/HOAC

Other (list): _____

Special Area(s) of Interest in Preventive Medicine: _____

Personal/Professional Info. of Interest (Spouse/Partner, Past Positions, Hobbies): _____

Board Certification: (ABPM or other required for Fellows)

Name of Board #1: _____ Yr.: _____ Number (if known): _____

Name of Board #2: _____ Yr.: _____ Number (if known): _____