

I am a:  New AGS Member  Renewing AGS Member

<b>Applicant Name</b>				<b>AGS ID #</b>
First Name	Middle Initial	Last Name	Degree (MD, DO, etc)	(if known)
<b>Mailing Address</b>			<b>Phone &amp; Email</b>	
Street and Number			[ ] Work	
City			[ ] Home	
State			Phone Number	
Zip			Fax Number	
Organization		Title	Date of Birth	<b>Email Address</b> (required for MyAGS and JAGS online)
If an AGS member recruited you, please print his/her Name			Recruiting Member's Email Address (if known)	

**AGS Membership is valid for one year from join/renew date. Please select your membership category:**

<p><b>Physician</b></p> <p>___ 1 year \$470      2 years \$940</p> <p><b>Nurse Practitioner</b></p> <p>___ 1 year \$322      2 years \$645</p> <p><b>Nurse</b></p> <p>___ 1 year \$322      2 years \$645</p> <p><b>Pharmacist</b></p> <p>___ 1 year \$322      2 years \$645</p> <p><b>Physician Associate</b></p> <p>___ 1 year \$322      2 years \$645</p> <p><b>Social Worker</b></p> <p>___ 1 year \$322      2 years \$645</p> <p><b>Other Healthcare Professional</b></p> <p>___ 1 year \$322      2 years \$645</p> <p><b>International Physician</b> (physicians residing in countries classified as low or middle income by the World Bank are eligible for discounts)</p> <p>___ 1 year (World Bank low income country) \$140</p> <p>___ 1 year (World Bank middle income country) \$290</p>	<p><b>Recognized</b> (health care professional who has returned to school full-time, while practicing)</p> <p>___ 1 year \$234</p> <p><b>Early Career Professional</b> (available for first year of practice after fellowship or residency)</p> <p>___ 1 year \$195</p> <p><b>Fellow-in-Training</b></p> <p>___ 1 year \$130</p> <p><b>Resident, Post-Grad/Pre-Doc Trainee</b></p> <p>___ 1 year \$0</p> <p><b>Student</b></p> <p>___ 1 year \$0</p> <p><b>Retired</b> (must be at least 60 years old or working less than 20 hours each week in active practice)</p> <p>___ 1 year \$95</p> <p><b>Emeritus</b> (members who have been active AGS members for 15 consecutive years)</p> <p>___ 1 year \$95</p>
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**AGS manages membership for the following state affiliates. If you'd like to become a member of your local state affiliate select it below or go to [www.americangeriatrics.org/stateaffiliates](http://www.americangeriatrics.org/stateaffiliates).**

___ California	___ Florida	___ Indiana	___ Virginia
___ Missouri	___ New Jersey	___ Ohio	___ West Virginia

**Applicant Name:** \_\_\_\_\_

**AGS Member Services:**

Yes, I would like my information listed in the HealthinAging.org Geriatrics Healthcare Professional Referral Service

<b>Referral Address</b>	<input type="checkbox"/> Work	<input type="checkbox"/> Home	<b>Referral Phone &amp; Email</b>
_____			_____
Street and Number			Phone Number
_____			_____
City	State	Zip	Fax Number
_____			
Organization	Title		

- No, I would not like to receive hard copy mailings of the AGS Journal (JAGS)  
 No, I would not like to receive hard copy mailings of *Annals of Long-Term Care*  
 No, I would not like to receive weekly listserv email updates

**Discipline:**  Medicine  Nurse  Nurse Practitioner  Pharmacist  Physical or Occupational Therapist  
 Physician Associate  Social Worker  Other Professional

**Certification Information:**

*Primary Specialty:*  Emergency Medicine  Family Medicine  Geriatric Medicine  Internal Medicine  
 Miscellaneous/Other, please specify \_\_\_\_\_

Certifying Agency	Specialty	Year Certified	Recertified (Y/N)	Year Recertified

**Verification information for Early Career Professionals, Fellows-in-Training, Residents and Student Members. Please complete the appropriate section:**

**Early Career Professional:** Name of Last Training Program: \_\_\_\_\_ Date of Program Completion: \_\_\_\_\_

**Fellow-in-Training:** Program Name: \_\_\_\_\_ Start Date: \_\_\_\_\_  
 End Date: \_\_\_\_\_ Director Name: \_\_\_\_\_ Director Email: \_\_\_\_\_

**Resident or Post Graduate:** Program Name: \_\_\_\_\_ Start Date: \_\_\_\_\_  
 End Date: \_\_\_\_\_ Director Name: \_\_\_\_\_ Director Email: \_\_\_\_\_

**Student/Recognized:** Program Name: \_\_\_\_\_ Start Date: \_\_\_\_\_  
 End Date: \_\_\_\_\_ Director Name: \_\_\_\_\_ Director Email: \_\_\_\_\_  
 Student Type:  Medical  Undergraduate Nursing  Graduate Nursing  Pharmacy  Other \_\_\_\_\_

**Voluntary Contribution to the Health in Aging Foundation:**  
 To the Healthy Aging Fund (general)(supports health professional trainees) \_\_\_\_\_ \$25 \_\_\_ \$50 \_\_\_ \$75 \_\_\_ Other \_\_\_  
 To the Student Researcher Fund \_\_\_\_\_ \$25 \_\_\_ \$50 \_\_\_ \$75 \_\_\_ Other \_\_\_

I consent to AGS charging my credit card with the above dues rate or enclosed is my check payable to: The American Geriatrics Society  
 Please charge to: \_\_\_ Visa \_\_\_ MasterCard \_\_\_ American Express \_\_\_ Discover  
 Credit Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_ CVV: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_