



# NEW YORK STATE PODIATRIC MEDICAL ASSOCIATION

Thank you for your interest in joining the New York State Podiatric Medical Association! Please find the Membership Application below.

Please include the following required documents with your application:

- Copy of **New York State** license
- Resume/CV
- Proof of malpractice insurance
- Letter from employer on company-stationary confirming current employment; or personal practice stationary if self employed

Applications and additional documents can be sent via the following methods:

- Faxed to 646-672-9344
- Emailed to [nsaari@nyspma.org](mailto:nsaari@nyspma.org)
- Mailed to NYSPMA, Attn: Nora Saari, 555 Eighth Avenue, Suite 1902, New York, NY 10018

The Association's fiscal year begins May 1, and your dues will be pro-rated to the date on which membership begins.

We look forward to welcoming you as a new member!

Sincerely,  
Lori Sales-Cutler  
Membership Director



# AMERICAN PODIATRIC MEDICAL ASSOCIATION

Web site: www.apma.org  
E-mail: membership\_ask\_apma@apma.org  
1-800-ASK-APMA

## Application for Membership

I hereby apply for membership in the component association of the state in which I have my principal practice and to the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulations of my component association and the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

**Please type or print clearly.**

Attach additional sheet of paper if needed.

Birth date, gender, and ethnic group are requested for statistical purposes.

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Previous Last Name (*changed due to marriage, divorce, etc.*) \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Nickname \_\_\_\_\_

Gender:  M  F Ethnic Group (*for demographic use only*):  Caucasian  African American  
 Hispanic  Asian/Pacific  American Indian  Other \_\_\_\_\_

Spouse's Name \_\_\_\_\_ US Citizen (*optional*):  Yes  No

**Complete all addresses below.**

Please note your preferred mailing address by placing a check mark in the box to the left of that address.

\*Your home address is essential for identifying and contacting your federal and state legislators through APMA's e-Advocacy program.

\*\*Please include your e-mail address as APMA communicates many important issues via e-mail.

**Home Address\*:** \_\_\_\_\_

\_\_\_\_\_ County \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Home e-mail\*\* : \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Pager ( ) \_\_\_\_\_

**Principal Office/Residency Address:** \_\_\_\_\_

\_\_\_\_\_ County \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Office e-mail\*\* : \_\_\_\_\_ Office Web Site: \_\_\_\_\_

**Second Office Address:** \_\_\_\_\_

\_\_\_\_\_ County \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Office e-mail\*\* : \_\_\_\_\_ Office Web Site: \_\_\_\_\_

**Third Office Address:** \_\_\_\_\_

\_\_\_\_\_ County \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Office e-mail\*\* : \_\_\_\_\_ Office Web Site: \_\_\_\_\_

*If you have more than three office addresses, please list on a separate sheet.*

## Education

**Undergraduate Degree** Year \_\_\_\_\_ State \_\_\_\_\_ Institution \_\_\_\_\_ Degree \_\_\_\_\_

**Graduate Degree** Year \_\_\_\_\_ State \_\_\_\_\_ Institution \_\_\_\_\_ Degree \_\_\_\_\_

**Podiatric Medical Degree**

(See back panel for listings)

Check College Below Year of Graduation \_\_\_\_\_  Arizona  Barry  California  
 Des Moines  New York  Ohio  Temple  Scholl  Western  Other

**Postgraduate Education**

Yes (If yes, complete)  No

If you have more than two fellowships or residencies, please list on a separate sheet.

Preceptorship

Fellowship

Residency (check one only):

Rotating Podiatric Residency (RPR)

Podiatric Orthopedic Residency (POR)

Primary Podiatric Medical Residency (PPMR)

Primary Surgical Residency (PSR)

Podiatric Medicine and Surgery Residency (PM+S)

Begin Date \_\_\_\_\_ State \_\_\_\_\_ Institution \_\_\_\_\_ Completion Date \_\_\_\_\_  
mo / yr mo / yr

Preceptorship

Fellowship

Residency (check one only):

Rotating Podiatric Residency (RPR)

Podiatric Orthopedic Residency (POR)

Primary Podiatric Medical Residency (PPMR)

Primary Surgical Residency (PSR)

Podiatric Medicine and Surgery Residency (PM+S)

Begin Date \_\_\_\_\_ State \_\_\_\_\_ Institution \_\_\_\_\_ Completion Date \_\_\_\_\_  
mo / yr mo / yr

## Military

**Military Service**

USA  USAF  USN  USMC  USCG Other \_\_\_\_\_

Date Entered \_\_\_\_\_ Date Separated \_\_\_\_\_ Current Rank \_\_\_\_\_

Reserves If yes, branch of service \_\_\_\_\_

## Professional Licensure

**Podiatric Medical Licenses**

Year \_\_\_\_\_ State \_\_\_\_\_ Number \_\_\_\_\_ Year \_\_\_\_\_ State \_\_\_\_\_ Number \_\_\_\_\_

Year \_\_\_\_\_ State \_\_\_\_\_ Number \_\_\_\_\_ Year \_\_\_\_\_ State \_\_\_\_\_ Number \_\_\_\_\_

Year \_\_\_\_\_ State \_\_\_\_\_ Number \_\_\_\_\_ Year \_\_\_\_\_ State \_\_\_\_\_ Number \_\_\_\_\_

Have you ever had a license to practice podiatric medicine suspended, denied, or revoked by any licensure authority?

Yes (If yes, please explain on a separate sheet.)  No

Are you currently, or have you ever been, on probation, suspension, or investigation by any licensure authority, state, or federal agency?

Yes (If yes, please explain on a separate sheet.)  No

## Podiatric Medical Practice

**Original Practice Start Date**

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

## APMA-Recognized Organizations

(check only those in which you have certification/membership)

### Board Certification

(See back panel for listings) If you are interested in learning more about qualification or certification in these organizations, go to [www.apma.org/certifyingboards](http://www.apma.org/certifyingboards)

ABPS     ABPOPPM

### Affiliated Membership

(See back panel for listings) If you are interested in learning more about membership in these organizations, go to [www.apma.org/affiliated](http://www.apma.org/affiliated)

AAHHP     AAPP     AAPSM     AAWP     ACFAOM  
 ACFAP     AENS     APMWA     ASPD     ASPM     ASPS

## Previous Member of APMA

Yes (If yes, complete)     No

Dates \_\_\_\_\_ Component Association \_\_\_\_\_

## Signature/Instructions

Please be aware that you may be required to provide additional documentation (copy of all state licenses, business card, sample of stationery, etc.) to your component society.

I understand that dual membership (state component and national association) is required to be a member in good standing. I agree not to represent myself as a member of APMA or my component, if for any reason, I cease to be a member in good standing. I also understand that a portion of my annual dues is in payment for a one year subscription for the **APMA NEWS** and for the **Journal of the American Podiatric Medical Association**. I agree that incomplete or false information may be grounds for denial or termination of membership.

APMA dues are not deductible as a charitable contribution for federal tax purposes but may be deductible as a business expense.

**If you are a practicing DPM, it is important to contact the state component in which your primary practice is located.** Contact information can be found on-line at [www.apma.org/StateComponents](http://www.apma.org/StateComponents). Your component will inform you of the amount of dues to remit as well as any other required documentation. An overview of membership processing procedures of each component can be viewed at [www.apma.org/MembershipProcess](http://www.apma.org/MembershipProcess). Your completed application and dues payment must be sent directly to your component, not the APMA.

**If you are a DPM in post-graduate training, send your completed application and dues payment directly to APMA.** A current dues chart for DPMs in post-graduate training can be viewed at [www.apma.org/PostGraduateDuesSchedule](http://www.apma.org/PostGraduateDuesSchedule).

If you have any questions, please contact the APMA Membership Services department at 1-800-ASK-APMA.

Applicant Signature: \_\_\_\_\_, DPM    Date: \_\_\_\_\_

I was recruited for APMA membership by the following APMA member:

\_\_\_\_\_

## Listing of Podiatric Medical Colleges

Arizona:	Arizona Podiatric Medicine Program at Midwestern University—Glendale
Barry:	Barry University School of Podiatric Medicine
California:	California School of Podiatric Medicine at Samuel Merritt University
Des Moines:	Des Moines University College of Podiatric Medicine & Surgery
New York:	New York College of Podiatric Medicine
Ohio:	Ohio College of Podiatric Medicine
Temple:	Temple University School of Podiatric Medicine
Scholl:	Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine & Science
Western:	Western University of Health Sciences College of Podiatric Medicine

## Listing of Boards

If you are interested in learning more about qualification or certification in these organizations, go to [www.apma.org/certifyingboards](http://www.apma.org/certifyingboards)

ABPOPPM	American Board of Podiatric Orthopedics and Primary Podiatric Medicine
ABPS	American Board of Podiatric Surgery

## Listing of Affiliated Organizations

If you are interested in learning more about membership in these organizations, go to [www.apma.org/affiliated](http://www.apma.org/affiliated)

AAHHP	American Association of Hospital and Healthcare Podiatrists
AAPPM	American Academy of Podiatric Practice Management
AAPSM	American Academy of Podiatric Sports Medicine
AAWP	American Association for Women Podiatrists
ACFAOM	American College of Foot and Ankle Orthopedics and Medicine
ACFAP	American College of Foot and Ankle Pediatrics
AENS	Association of Extremity Nerve Surgeons
APMWA	American Podiatric Medical Writers' Association
ASPD	American Society of Podiatric Dermatology
ASPM	American Society of Podiatric Medicine
ASPS	American Society of Podiatric Surgeons

### For Component Society Use

Component name: \_\_\_\_\_

Division (If applicable): \_\_\_\_\_

Date application was received: \_\_\_\_\_

Date sent to APMA: \_\_\_\_\_

Join date: \_\_\_\_\_

Member category: \_\_\_\_\_

### For APMA Use Only

Dues Amount	_____
Member No.	_____
Member Type	_____
Date Received	_____
Elect Date	_____

## **Consent to Release of Information**

I hereby consent to the release of all information, and release from any liability any and all individuals and organizations providing such information to the New York State Podiatric Medical Association or its authorized representatives, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for my joining the New York State Podiatric Medical Association.

I certify that the information contained in this application is complete and correct to the best of my knowledge, and I understand that the falsification of this information is grounds for revocation of approval.

\_\_\_\_\_, DPM  
**Name of Podiatrist**

\_\_\_\_\_  
**Signature**

**Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone:**(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_, DPM

**HISTORY OF PRACTICE** (All questions must be answered fully & accurately)

1. Has your current or any past license to practice your profession ever been suspended within the past 10 years?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
2. Have your privileges at any hospital ever been denied, suspended, or revoked?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
3. Have you ever been denied membership or been subject to reprimand, censure or otherwise disciplined by any medical organization?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
4. Has your narcotics registration ever been suspended, restricted, cancelled or relinquished?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
5. Do you have malpractice insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Please return a current Certificate of Insurance with this form.
6. Has your malpractice insurance ever been suspended, cancelled or not renewed?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
7. Have you ever been party to a professional malpractice suit in which a judgment of liability was entered against you or in which a suit was resolved by a settlement or payment by you or your insurer?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
8. Have you ever been suspended as a Medicare or Medicaid Provider in the past 10 years?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
9. Have you ever had treatment for chemical dependency or have you ever been in a drug or alcohol rehabilitation program?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
10. Have you ever been convicted of any criminal charges other than minor traffic offenses?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.
11. Have you ever been convicted of any crime related to your practice of medicine, including Medicare or Medicaid related fines?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain below.