



National Association of EMS Physicians
 P.O. Box 15945-281 • Lenexa, KS 66285-5945
 (913) 895-4611 or (800) 228-3677 • Fax: (913) 895-4652

MEMBERSHIP APPLICATION

Full Name: _____
 (Include academic accomplishments such as MD, DO, MPH, PhD, EMT-P, EMT, RN etc.) Limit 3

Please check below accordingly. Preferred Mail: All membership mailings and renewal notices will be sent to this address.

HOME ADDRESS – Preferred Mail

Mailing Address: _____

City: _____ State/Province: _____

Zip: _____ Country: _____

Phone: _____ Fax: _____ E-mail: _____

BUSINESS ADDRESS – Preferred Mail

Company/Institution (if applicable): _____

Mailing Address: _____

City: _____ State/Province: _____

Zip: _____ Country: _____

Phone: _____ Fax: _____ E-mail: _____

Are you a Medical Director? YES NO

Primary EMS Affiliation Role or Title: _____

In what environment is your primary EMS affiliation located?

Urban Suburban Rural Frontier Other: _____

Medical specialty (physicians): _____

Non-physician primary medical specialty:

- | | | |
|--|---|--|
| <input type="checkbox"/> Paramedic | <input type="checkbox"/> EMT-Basic | <input type="checkbox"/> EMT-Intermediate |
| <input type="checkbox"/> EMT-Paramedic | <input type="checkbox"/> EMD | <input type="checkbox"/> First Responder |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Research | <input type="checkbox"/> Education |
| <input type="checkbox"/> Medical Student | <input type="checkbox"/> Administrative | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Other: _____ | | |

Employer Type:

- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Fire Department | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Hospital-based |
| <input type="checkbox"/> 3rd Service Government | <input type="checkbox"/> Industrial | <input type="checkbox"/> Commercial/Private |
| <input type="checkbox"/> Academic | <input type="checkbox"/> Military | |
| <input type="checkbox"/> Other: _____ | | |

How did you hear about us? _____

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Membership Application – page 2

Membership Categories:

- Physician member:** \$275.00.
Physicians who are engaged in the planning, supervision, teaching or clinical practice of out-of-hospital emergency medical care.
- Professional member:** \$135.00.
Non-physicians who have demonstrated an interest in out-of-hospital emergency medical care and the aims of the Association. (Nurse, EMT, EMT-P etc.)
- International member:** \$135.00.
EMS Physicians outside of North America. Members in this category do not receive NAEMSP News and Prehospital Emergency Care Journal via the mail. These publications are only available on-line.
- Fellow member:** \$135.00.
Fellow interested in EMS.
Expected graduation date: _____
(Please include a verification letter from your fellowship director.)
- Resident physician member:** \$105.00.
Resident physicians interested in EMS.
Expected graduation date: _____
(Please include a verification letter from your residency director.)
- Medical student member:** \$75.00.
Medical students interested in EMS.
Expected graduation date: _____
(Please include a verification letter from your medical school.)

Payment:

- Check/money order enclosed Visa MasterCard American Express

Credit Card Number: _____

Exp. Date: _____

Signature: _____

Date: _____

**No purchase orders will be accepted by NAEMSP.
NAEMSP does not bill or invoice for membership.
Payment must be included for the application to be considered complete.**

Please enclose check, money order or credit card information for payment (in U.S. funds) and return to:

NAEMSP
P.O. Box 15945-281
Lenexa, KS 66285-5945
Phone: (913) 895-4611 or (800) 228-3677
Fax: (913) 895-4652

**E-mail us at: info-naemsp@goAMP.com
Visit us on our website at: www.naemsp.org**