



**Naval Association of Physician Assistants**  
**950 N. Washington Street, Alexandria, VA 22314-1552**  
**Membership Application**

Name: \_\_\_\_\_

Place of Work: \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Work Fax: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Educational Program: \_\_\_\_\_ Completed: \_\_\_\_\_

NCCPA Certification: YES NO AAPA Member: YES NO AAPA #: \_\_\_\_\_

New Member       Membership Renewal       Change of Address

Membership Types (*check one*):

- Fellow**      **\$30**      Affords full voting privileges and right to serve as a NAPA officer; current AAPA fellow membership required.
- Lifetime**      **\$300**      One-time fee affords lifetime membership as a fellow of NAPA.
- Affiliate**      **\$30**      PAs eligible for fellow membership who chooses not to belong to AAPA; affords no voting privileges.
- Associate**      **\$150**      Representatives of businesses engaged in selling products or services to PAs; affords no voting privileges.
- Student**      **Free**      Open to students currently enrolled in Navy sponsored PA programs; Free until after graduation. Grad. Date \_\_\_\_\_

For our database please mark one. \_\_\_\_\_ Active Duty \_\_\_\_\_ Reserve \_\_\_\_\_ Retired \_\_\_\_\_ Other

I am interested in volunteering for a committee or other position in NAPA.       Yes       No

***Please include a check or money order for payment. We also accept credit card payments (circle one):***  
 Visa/MC/AMEX

**Name on Card:** \_\_\_\_\_ **Card Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **Authorized Signature:** \_\_\_\_\_

I hereby apply for membership in the Naval Association of Physician Assistants and agree to abide by the Constitution and Bylaws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(FOR FELLOW MEMBERS ONLY) - I also certify that I am a current member of the American Academy of Physician Assistants and wish to be represented in the House of Delegates by the Naval Association of Physician Assistants.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_