Important Notice: Please fill out this application legibly. DPM's applying for membership must be a member in good standing with the **APMA.** Please Note: A $25.00 fee will be charged on all returned checks.

DPM $100.00 (one-time membership fee)

Podiatrist Name: _____APMA#: _____

Office: _____

Address: _____City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Email address:_____

Cell phone:_____

The application fee must accompany this form. Checks should be made payable to ASPMA. Remember DPM's must recertify every May with 20 CME's and a $55.00 recertification fee.

Send completed membership form and payment to: ASPMA
9007 W. High St
Yorktown, IN 47396

If you have any questions, please call the ASPMA Office at 1-888-88ASPMA or email us at aspmaex@aol.com.

For Office Use Only Check#: _____ Date Rcv'd: _____ Amount: _____