



**ARIZONA ASSISTANTS ONLY**  
**MEMBERSHIP AND RADIOLOGY CERTIFICATION REGISTRATION**

**Important Notice:** Please fill out this application legibly. Remember that to become a member of the ASPMA, the assistant must be employed by a DPM who's a member in good standing of the APMA is.

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

Podiatrist Name: \_\_\_\_\_ APMA#: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Length of Employment: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Total Due: \$520 (includes Membership Fee, Radiology Study Guide, Radiology Certification Exam)**

Mail with a check made payable to **ASPMA** to:

**ASPMA**  
109 1<sup>st</sup> Street  
Itasca, IL 60143-2114  
Phone: 888-882-7762

A \$25.00 fee will be charged for all returned checks.

OR

Fax with credit card information and signature to 847-773-9976

Circle One: VISA    MasterCard    Discover    American Express

Name as it appears on card: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_ CVV Code: \_\_\_\_\_

Billing Address (if different than above): \_\_\_\_\_

Email (For Receipt): \_\_\_\_\_

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

**\*Upon receipt of registration form and fee please allow up to 2-3 weeks for membership packet and radiology study guide to be shipped\***