



AARS MEMBERSHIP APPLICATION

A. APPLICANT INFORMATION			
*Name:		*Degree:	
*Title:		Department:	
*Employer/Company:			
*Email:	*Phone:	Fax:	
B. SHIPPING INFORMATION (We will mail your AARS Membership Packet to this address)			
*Street Address:		Address Line 2:	
*City:	*State:	*ZIP Code:	*Country:
C. *MEMBERSHIP			
<input type="radio"/>	Fellow US Physician/Dermatologist \$150.00 Annual Fee	<i>Eligible to any physician who is a resident of the United States and who is certified by (i) the American Board of Dermatology or (ii) the American Osteopathic College of Dermatology or who has training approximately equivalent to the requirements for certification by the American Board of Dermatology.</i>	CERTIFICATION (Select All That Apply) American Board of Dermatology ___/___/___ American Osteopathic College of Dermatology ___/___/___ American Academy of Pediatrics ___/___/___ Equivalent Board (International): _____ _____
<input type="radio"/>	Associate Non-US Physician/Other Specialty \$150.00 Annual Fee	<i>Eligible to any non-U.S. physician involved in dermatology either through clinical practice, teaching, research, or industry.</i>	Undergraduate: _____ Degree: _____ Year: _____ Medical or Graduate School: _____ Degree: _____ Year: _____ Residency (Post-graduate training): _____ Degree: _____ Year: _____ Other Specialty Training: _____ _____
<input type="radio"/>	Affiliate Nurse, Nurse Practitioner and Physician Assistant \$100.00 Annual Fee	<i>Eligible to any non-physician with a degree in a scientific discipline or allied health professional with involvement in dermatology that is employed by either a medical school, government organization or by a physician Fellow or Associate of AARS.</i>	
<input type="radio"/>	Resident Dermatology Resident \$50.00 Annual Fee	<i>Eligible to any dermatology resident in good standing in training at any approved training center.</i>	
D. *PAYMENT INFORMATION			
<input type="radio"/> Check <input type="radio"/> Visa <input type="radio"/> MasterCard <input type="radio"/> American Express <input type="radio"/> Discover <input type="radio"/> Cash			Please make checks payable to: American Acne and Rosacea Society
Credit Card Number:		Expiration Date:	Payment Amount:
Security Code:	Name as it appears on credit card:		
Credit Card Billing Address:			
City/State:		Zip Code:	
<input type="radio"/> Please renew my membership automatically. You will receive a reminder prior to automatic renewal. You can turn off automatic renewal at any time.			
Signature:			Today's Date:

***Required Field**

Note: The AARS is a 501(c)(3) non-profit public charity. Contributions to the AARS are tax deductible under §170 of the Internal Revenue Code. Use of the name of the American Acne and Rosacea Society and/or the Society logo on business stationary or in any advertisement is prohibited.