AMERICAN ASSOCIATION *OF* MEDICAL AUDIT SPECIALISTS

Group Membership Application

NOTE: Several emails are being bounced back when sent to employer emails. Therefore, please provide your personal email as the primary contact and mark aamas.org as "safe".

Please Print Clearly:

Name: Dr. / Mrs. / Mr. / Ms. _____ Date: _____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

θ **Group Membership** If three or more employees from the same organization join/renew, they each receive the discounted rate noted below. Please provide names and contact information on the second page of this form.

Total Number of Members: 0 x $125.00 = Total Membership Cost $ 0.00

OPTIONAL: ☐

Please check this box to help AAMAS defray the cost of credit card processing fees by adding 3.5% to your total. (3.5% = $ 0.00)

Total Approved Payment $ 0.00

PAYMENT INFORMATION:

Check/Money Order ◯ Visa ◯ MasterCard ◯ Discover ◯ American Express ◯

Card Number: _____ Exp. Date: _____

Name on Card: _____ CVV Code: _____

Signature: _____

Return this form with your payment. Checks or money orders (in U.S. dollars) payable to AAMAS

7044 S 13th St.

Oak Creek, WI 53154, USA Tel: 414-908-4941

Credit Card Payments can be faxed to AAMAS at **414-768-8001**.

TOTAL DUE: 0.00

Please FAX or MAIL your application to the address on the left.

Additional Group Members:

1. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

2. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

3. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

4. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

5. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

6. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

7. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail: _____

Work E-mail: _____

8. Name: Dr. / Mrs. / Mr. / Ms._____Date:_____

Title: _____ Credentials: _____

Affiliation: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Cell Phone: _____ Personal E-mail:_____

Work E-mail: _____