Pennsylvania Society of Physician Assistants
PO Box 128, Greensburg, PA 15601
www.PSPA.net PSPA@pspa.net

GROUP MEMBERSHIP FORM

If you have several people from the same facility joining, simply fill out the following information!

FACILITY NAME:_____
Mailing Address for the Office:_____

_____

City:_____ County:_____

State:_____ Zip:_____ Office Phone Number:_____

PRIMARY PHYSICIAN ASSISTANT CONTACT

Name:_____

Preferred Phone: _____

Email: _____ Month of Birth:_____

Please check the membership category for which you are applying:
_____ Fellow $135.00 (AAPA member practicing and / or residing in Pennsylvania)
_____ Affiliate $135.00 (non-AAPA member practicing and / or residing in Pennsylvania)
_____ Sustaining $60.00 (PA not practicing in Pennsylvania, or other health professional)
PA Program Attended /Attending: _____Year of Graduation:_____
Current AAPA Membership no._____
NCCPA Certificate No.:_____ State Board No.:_____
Practice Setting: Urban _____, Rural _____, or Suburban _____
Practice Location: Office_____ Hospital _____, or Other(please specify)_____
Specialty: _____
PA Signature_____ Date_____

TOTALS:
Fellow Members _____ x $135.00 = _____
Affiliate Members _____ x $135.00 = _____
Sustaining Members _____ x $60.00 = _____
Total Due: _____

Payment by Check____ (made out to PSPA) or Credit Card_____ Type of Card _____
Card Number: _____
Card Expiration Date: _____
Card Holder Name: _____
Signature_____ Date_____

You can fax the form to 724-836-4449 or mail to PSPA at PO Box 128, Greensburg, PA 15601

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PHYSICIAN ASSISTANT

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Preferred Phone: _____

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Attach additional copies of this page as needed

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