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

Joint Physician - Physician Assistant Membership Form

Practice Name:_____

Practice Address:_____

City / State / Zip:_____

Practice Phone:_____

Number of years you have worked together:_____
Practice Setting: Urban _____, Rural _____, or Suburban _____
Practice Location: Office_____ Hospital _____, or Other (please specify)_____

PHYSICIAN

Name:_____
Preferred Phone:_____
E-mail address:_____
If you'd like mailings to another address, please list:

Are you a member of the PA Medical Society or Osteopathic Medical Society? YES NO
Are you a member of another Pennsylvania medical group? YES NO
If yes, please list:

Physician Signature_____ Date_____

PHYSICIAN ASSISTANT

Name:_____
Preferred Phone:_____ County of Home Residence:_____
E-mail address:_____ Month of Birth:_____
If you'd like mailings to another address, please list:

PA Program Attended: _____ Year of Graduation:_____
Current AAPA Membership no._____
NCCPA Certificate No.:_____ State Board Number/Numbers:_____
Specialty: _____
PA Signature_____ Date_____

Joint Membership Fee $185
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