

I am a: ☐ New AGS Member ☐ Renewing AGS Member

Applicant Name				AGS ID #
First Name	Middle Initial	Last Name	Degree (MD, DO, etc)	(if known)
<b>Mailing Address</b>				<b>Phone &amp; Email</b>
Street and Number			[ ] Work	
City			Phone Number	
State			[ ] Home	
Zip			Fax Number	
Organization		Title		Date of Birth
		<b>Email Address</b> (required for MyAGS and JAGS online)		
If an AGS member recruited you, please print his/her Name			Recruiting Member's Email Address (if known)	

**AGS Membership is valid for one year from join/renew date. Please select your membership category:**

<p><b>Physician</b></p> <p>___ 1 year \$415</p> <p>___ 2 years \$830</p> <p><b>Nurse/Nurse Practitioner or other Health Care Professional</b></p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p><b>Pharmacist</b></p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p><b>Physician Assistant</b></p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p><b>Social Worker</b></p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p><b>International Physician</b> (physicians residing in countries classified as low or middle income by the World Bank are eligible for discounts)</p> <p>___ 1 year (World Bank low income country) \$130</p> <p>___ 1 year (World Bank middle income country) \$270</p>	<p><b>Recognized</b> (health care professional who has returned to school full-time, while practicing)</p> <p>___ 1 year \$234</p> <p><b>Early Career Professional</b> (available for first year of practice after fellowship or residency)</p> <p>___ 1 year \$171</p> <p><b>Fellow-in-Training</b></p> <p>___ 1 year \$120</p> <p><b>Resident, Post-Grad/Pre-Con Trainee</b></p> <p>___ 1 year \$102</p> <p><b>Student</b></p> <p>___ 1 year \$78</p> <p><b>Retired</b> (must be at least 60 years old or working less than 20 hours each week in active practice)</p> <p>___ 1 year \$87</p> <p><b>Emeritus</b> (members who have been active AGS members for 15 consecutive years)</p> <p>___ 1 year \$87</p>
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**AGS manages membership for the following state affiliates. If you'd like to become a member of your local state affiliate select it below or go to [www.americangeriatrics.org/stateaffiliates](http://www.americangeriatrics.org/stateaffiliates).**

___ California	___ Florida	___ Illinois	___ Virginia
___ Missouri	___ New Jersey	___ Ohio	___ West Virginia

**Applicant Name:**

**AGS Member Services:**

☐ Yes, I would like my information listed in the HealthinAging.org Geriatrics Healthcare Professional Referral Service

**Referral Address**

**Referral Phone & Email**

\_\_\_\_\_  
Street and Number

☐ Work

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City State Zip

☐ Home

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Title

☐ No, I would not like to receive hard copy mailings of the AGS Journal (JAGS)

☐ No, I would not like to receive hard copy mailings of *Annals of Long-Term Care*

☐ No, I would not like to receive weekly listserv email updates

**Discipline:** ☐ Medicine ☐ Nurse/Nurse Practitioner ☐ Pharmacist ☐ Physical or Occupational Therapist  
☐ Physician Assistant ☐ Social Worker ☐ Other Professional

**Certification Information:**

*Primary Specialty:* ☐ Emergency Medicine ☐ Family Medicine ☐ Geriatric Medicine ☐ Internal Medicine

☐ Miscellaneous/Other, please specify \_\_\_\_\_

Certifying Agency	Specialty	Year Certified	Recertified (Y/N)	Year Recertified

**Verification information for Early Career Professionals, Fellows-in-Training, Residents and Student Members. Please complete the appropriate section:**

**Early Career Professional:** Name of Last Training Program: \_\_\_\_\_ Date of Program Completion: \_\_\_\_\_

**Fellow-in-Training:** Program Name: \_\_\_\_\_ Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_ Director Name: \_\_\_\_\_ Director Email: \_\_\_\_\_

**Resident or Post Graduate:** Program Name: \_\_\_\_\_ Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_ Director Name: \_\_\_\_\_ Director Email: \_\_\_\_\_

**Student/Recognized:** Program Name: \_\_\_\_\_ Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_ Director Name: \_\_\_\_\_ Director Email: \_\_\_\_\_

Student Type: ☐ Medical ☐ Undergraduate Nursing ☐ Graduate Nursing ☐ Pharmacy ☐ Other \_\_\_\_\_

**Voluntary Contribution to the Health in Aging Foundation:**

To the Healthy Aging Fund (general)(supports health professional trainees)

To the Student Researcher Fund

\_\_\_ \$25 \_\_\_ \$50 \_\_\_ \$75 \_\_\_ Other \_\_\_

\_\_\_ \$25 \_\_\_ \$50 \_\_\_ \$75 \_\_\_ Other \_\_\_

☐ Enclosed is my check payable to: The American Geriatrics Society

☐ Please charge to: \_\_\_ Visa \_\_\_ MasterCard \_\_\_ American Express \_\_\_ Discover

Credit Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

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

**Once completed, please click "submit" in the upper right-hand corner of this document.**