

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)	
Mailing Address				Phone & Email	
Street and Number			[] Work		
City			State		
Zip			Phone Number		
Organization			Title		
Date of Birth			Fax Number		
Email Address (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>Physician</p> <p>___ 1 year \$415</p> <p>___ 2 years \$830</p> <p>Nurse/Nurse Practitioner or other Health Care Professional</p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p>Pharmacist</p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p>Physician Assistant</p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p>Social Worker</p> <p>___ 1 year \$322</p> <p>___ 2 years \$645</p> <p>International Physician (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>Recognized (health care professional who has returned to school full-time, while practicing)</p> <p>___ 1 year \$234</p> <p>Early Career Professional (available for first year of practice after fellowship or residency)</p> <p>___ 1 year \$171</p> <p>Fellow-in-Training</p> <p>___ 1 year \$120</p> <p>Resident, Post-Grad/Pre-Con Trainee</p> <p>___ 1 year \$102</p> <p>Student</p> <p>___ 1 year \$78</p> <p>Retired (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>Emeritus (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.

___ 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

☐ Work

☐ Home

Referral Phone & Email

Street and Number

Phone Number

City

State

Zip

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 ___

I consent to AGS charging my credit card with the above dues rate or 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: _____

Please select "submit form" in the upper-right hand corner of the page to send to AGS or email us at membership@americangeriatrics.org. You can also print and send this application to The American Geriatrics Society 18th floor New York, NY 10038