Membership Application

MEMBERSHIP CLASSIFICATION

- ❑ Patient or Family Membership ($25)
- ❑ Professional Membership ($35)
- ❑ Sustaining/Physician Membership ($100)
- ❑ Institutional/Dialysis Unit/Transplant Center Membership ($150)
- ❑ Life Membership ($1,000)

For Memberships outside the United States of America, please add an additional $30 for foreign postage.

MEMBER INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Country _____

Daytime Phone ( ) _____ E-mail Address _____

GIFT INFORMATION

❑ Enclosed is my membership fee of $_____ (Please make check payable to AAKP.)

❑ Please charge my credit card for my membership fee of $_____

❑ Discover® ❑ MasterCard® ❑ Visa® ❑ American Express®

Credit Card Number _____ Expiration Date _____

Name on Card _____

Signature _____

Please return this membership application to:
American Association of Kidney Patients
3505 East Frontage Road, Suite 315
Tampa, FL 33607-1769
Fax: (813) 636-8122