AGS Geriatrics Healthcare Professionals

THE AMERICAN GERIATRICS SOCIETY
40 FULTON STREET, 18TH FLOOR
NEW YORK, NEW YORK 10038
212.308.1414 TEL 212.832.8646 FAX
www.americangeriatrics.org

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

Applicant Name

First Name ____ Middle Initial ____ Last Name ____ Degree (MD, DO, etc) ____

AGS ID # ____ (if known)

Mailing Address

Street and Number ____

City ____ State ____ Zip ____

Organization ____ Title ____

Phone & Email

[ ] Work Phone Number ____

[ ] Home Fax Number ____

Date of Birth ____

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:

Physician

___ 1 year $440
___ 2 years $880

Nurse/Nurse Practitioner or other Health Care Professional

___ 1 year $322
___ 2 years $645

Pharmacist

___ 1 year $322
___ 2 years $645

Physician Assistant

___ 1 year $322
___ 2 years $645

Social Worker

___ 1 year $322
___ 2 years $645

International Physician *(physicians residing in countries classified as low or middle income by the World Bank are eligible for discounts)*

___ 1 year (World Bank low income country) $133
___ 1 year (World Bank middle income country) $275

Recognized *(health care professional who has returned to school full-time, while practicing)*

___ 1 year $232

Early Career Professional *(available for first year of practice after fellowship or residency)*

___ 1 year $180

Fellow-in-Training

___ 1 year $130

Resident, Post-Grad/Pre-Doc Trainee

___ 1 year $100

Student

___ 1 year $82

Retired *(must be at least 60 years old or working less than 20 hours each week in active practice)*

___ 1 year $90

Emeritus *(members who have been active AGS members for 15 consecutive years)*

___ 1 year $90

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

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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

____
Street and Number

____
City State Zip

____
Organization Title

Referral Phone & Email

____
Phone Number

____
Fax Number

[ ] 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)

___ $25 ___ $50 ___ $75 ___ Other ____

To the Student Researcher Fund

___ $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