

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			[] Home	
State		Zip	Phone Number	
Organization		Title	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:

<p>Physician</p> <p>___ 1 year \$455</p> <p>___ 2 years \$910</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) \$138</p> <p>___ 1 year (World Bank middle income country) \$285</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 \$195</p> <p>Fellow-in-Training</p> <p>___ 1 year \$130</p> <p>Resident, Post-Grad/Pre-Doc Trainee</p> <p>___ 1 year \$110</p> <p>Student</p> <p>___ 1 year \$100</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 \$95</p> <p>Emeritus (members who have been active AGS members for 15 consecutive years)</p> <p>___ 1 year \$95</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)

___ \$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 sign me up for Auto-Renewal.

Credit Card Number: _____ Exp Date: _____ CVV: _____

Signature: _____ Date: _____