

**Please check one:**

New Member     Renewal ( My contact info has not changed)    Date: \_\_\_\_\_

**PROVIDER INFORMATION (PLEASE PRINT CLEARLY)**

*Contact data for AAHIVM correspondence*

Name: \_\_\_\_\_

Provider Type:  MD     DO     PA     NP     Pharmacist     Other: \_\_\_\_\_

Additional Degrees: \_\_\_\_\_ AAHIVM ID# (if known): \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Home  Business  \_\_\_\_\_ Fax: \_\_\_\_\_  
 \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Gender:  Male     Female     Gender Nonconforming/Other  
(optional - select all that apply)

Ethnicity:  American Indian / Alaskan Native     Asian     Black or African American  
(optional - select all that apply)  Hispanic, Latinx, Spanish     Middle Eastern / North African     Native Hawaiian / Pacific Islander  
 White     Other: \_\_\_\_\_

# of HIV Patients in Care:  1-19     20-75     76-100     101-150     151-300     301+     Non-practicing

Principal Practice Setting:  Community Health Center     Correctional Facility     Health Department  
 HMO / Managed Care     Hospital / Hospital-Based Clinic     Industry / Research  
 Private Practice     Retail Pharmacy     V.A. / Government  
 Other: \_\_\_\_\_

Specialty:  ID     IM     FP     EM     OB/GYN     Pediatrics     Geriatrics  
 Other: \_\_\_\_\_

"Ryan White" Funding:  Yes     No     N/A    Anticipated Year of Retirement: \_\_\_\_\_

**INFORMATION FOR PUBLIC ONLINE PROVIDER DIRECTORY, *Referral Link***

Organization: \_\_\_\_\_

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_  
(if different from above)

Brief description of your practice for public display:

**Please return this form via one of the following methods:**

fax to: 202-659-0976, email scanned form to: aaron@aahivm.org, or mail to:  
 AAHIVM | 1627 Eye St. NW, Suite 835 | Washington, DC 20006 | 202-659-0699

**INFORMATION FOR PUBLIC ONLINE PROVIDER DIRECTORY, Referral Link (continued)**

Appointment Phone: \_\_\_\_\_ Website: \_\_\_\_\_

 Fee Policies / Insurance Options Accepted:  Medicare  Medicaid  Sliding Scale  
 Private Insurance  Other: \_\_\_\_\_

 Please mark the services that **YOU** offer patients with or at risk for HIV:

PRIMARY MEDICAL SERVICES	
<input type="checkbox"/>	Confirmatory HIV Testing
<input type="checkbox"/>	HIV Primary Care
<input type="checkbox"/>	GYN Care
<input type="checkbox"/>	Anal PAP Screening
<input type="checkbox"/>	Prenatal Care
<input type="checkbox"/>	Adolescent Care
<input type="checkbox"/>	Hepatitis C Mono-Infected
<input type="checkbox"/>	Hepatitis C Co-Infected
SPECIALTY CARE SERVICES	
<input type="checkbox"/>	Women's Health
<input type="checkbox"/>	Men's Health
<input type="checkbox"/>	Transgender Health
ADDITIONAL CLINICAL SERVICES	
<input type="checkbox"/>	Case Management
<input type="checkbox"/>	Substance Use Disorder Treatment - Outpatient
<input type="checkbox"/>	Substance Use Disorder Treatment - Residential
<input type="checkbox"/>	Mental Health Services
<input type="checkbox"/>	AIDS Drug Assistance Program (ADAP) access

ADDITIONAL CLINICAL SERVICES (CONT'D)	
<input type="checkbox"/>	HIV drug manufacturer pt. assistance program access
<input type="checkbox"/>	Access to clinical trials
<input type="checkbox"/>	Dental Care
<input type="checkbox"/>	Pharmacy Dispensing & Counseling
<input type="checkbox"/>	Pre-Exposure Prophylaxis (PrEP)
<input type="checkbox"/>	Post-Exposure Prophylaxis (PEP)
SUPPORT SERVICES	
<input type="checkbox"/>	Medical Nutrition Therapy
<input type="checkbox"/>	Pain Management
<input type="checkbox"/>	Hospice
<input type="checkbox"/>	Health insurance counseling/assistance
<input type="checkbox"/>	Translation / Bilingual care
<input type="checkbox"/>	Transportation
<input type="checkbox"/>	Ministry & Spiritual Services
<input type="checkbox"/>	Do not provide clinical services

**MEMBERSHIP DUES INFO (includes automatic enrollment as a Member of your state/regional chapter)**

- Annual** \$200  
 **Monthly** \$15/mo (credit card req.) \$180  
 **Multi-Year** (min. 2 years.)  
 \$180 / year x \_\_\_\_\_ years = \_\_\_\_\_

- HIV Treaters Association of Puerto Rico Member** \$75  
 **Fellow/Resident** \$40  
 **Retired** \$25

- Student** (for **non-licensed students** pursuing any of the following degree types: MD, DO, PA, NP, PharmD, RPh; providers holding any of these licenses are ineligible for complimentary Student Membership) **Complimentary**

**TOTAL \$** \_\_\_\_\_

- With submission of this application, **I agree** to AAHIVM's Code of Ethics (available at [www.aahivm.org](http://www.aahivm.org)).

 Payment Type:  Check enclosed  
 Credit Card (Visa, M/C or Amex)

Name on card: \_\_\_\_\_

Card #: \_\_\_\_\_

Exp Date: \_\_\_\_\_ CCV#: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

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

**IMPORTANT TAX NOTE:** AAHIVM is exempt from taxes as a non-profit 501(c) (6) organization. Please note that advocacy expenditures result in some restrictions on a member's ability to deduct membership fees as a business expense. See Internal Revenue Code Section 162 (e) (1). AAHIVM estimates that the non-deductible portion of your annual membership fee is twenty percent (20%).

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