AMERICAN ACADEMY OF HIV MEDICINE

# Membership/Renewal Application

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

Ethnicity: (optional - select all that apply) ☐ American Indian / Alaskan Native ☐ Asian ☐ Black or African American ☐ 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 | 1600 K St NW, Suite 350 | Washington, DC 20006 | 202-659-0699

AMERICAN ACADEMY OF HIV MEDICINE

# Membership Form

## 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 |
|---|---|
| | Confirmatory HIV Testing |
| | HIV Primary Care |
| | GYN Care |
| | Anal PAP Screening |
| | Prenatal Care |
| | Adolescent Care |
| | Hepatitis C Mono-Infected |
| | Hepatitis C Co-Infected |
| | **SPECIALTY CARE SERVICES** |
| | Women's Health |
| | Men's Health |
| | Transgender Health |
| | **ADDITIONAL CLINICAL SERVICES** |
| | Case Management |
| | Substance Use Disorder Treatment - Outpatient |
| | Substance Use Disorder Treatment - Residential |
| | Mental Health Services |
| | AIDS Drug Assistance Program (ADAP) access |

| | ADDITIONAL CLINICAL SERVICES (CONT'D) |
|---|---|
| | HIV drug manufacturer pt. assistance program access |
| | Access to clinical trials |
| | Dental Care |
| | Pharmacy Dispensing & Counseling |
| | Pre-Exposure Prophylaxis (PrEP) |
| | Post-Exposure Prophylaxis (PEP) |
| | **SUPPORT SERVICES** |
| | Medical Nutrition Therapy |
| | Pain Management |
| | Hospice |
| | Health insurance counseling/assistance |
| | Translation / Bilingual care |
| | Transportation |
| | Ministry & Spiritual Services |
| | 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).

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

Name on card: _____

Card #: _____

Exp Date: _____ CCV#: _____ Billing Zip: _____

Signature: _____

IMPORTANT TAX NOTE: AAHVIM 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 memberhip fee is twenty percent (20%).

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AAHIVM | 1600 K St NW, Suite 350 | Washington, DC 20006 | 202-659-0699 **www.aahivm.org**