



Division 55 of the American Psychological Association  
American Society for the Advancement of Pharmacotherapy  
**Application for Membership/Renewal of Membership**

Please complete the entire form, even if you are renewing your membership!

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Office Street Address: \_\_\_\_\_

Office City: \_\_\_\_\_ Office State: \_\_\_\_\_ Office Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

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

**Membership Categories:** Please mark one option:

- |   |         |   |             |
|---|---------|---|-------------|
| <input type="checkbox"/> Affiliate      | \$40.00 | <input type="checkbox"/> Discounted Membership              | \$20.00     |
| <input type="checkbox"/> Associate      | \$40.00 | Requirements: 1 <sup>st</sup> year new non-affiliate member |             |
| <input type="checkbox"/> Fellow         | \$40.00 | <input type="checkbox"/> Student Affiliate                  | \$10.00     |
| <input type="checkbox"/> Int. Affiliate | \$40.00 | <input type="checkbox"/> Life Member                        | Dues Exempt |
| <input type="checkbox"/> Member         | \$40.00 | Requirements: age: 65+; 25+ years APA membership            |             |

**Payment Information:**

**Circle one:** Credit Card Check

If paying by check, check #: \_\_\_\_\_

Credit Card Type: VISA MasterCard

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Name on Credit Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Billing City: \_\_\_\_\_ Billing State: \_\_\_\_\_ Billing Zip: \_\_\_\_\_

**Total Payment: \$** \_\_\_\_\_

**Signature** \_\_\_\_\_

Please mail application form to:

APA Division Services  
750 First Street NE  
Washington, DC 20002