CONTACT INFORMATION

☐ Dr. ☐ Mr. ☐ Ms. ☐ Jr. ☐ Sr. ☐ III ☐ IV ☐ V

First Name _____ Middle Name _____ Last Name _____

Degree: ☐ DO ☐ DPM ☐ LPN ☐ MD ☐ NP ☐ PA ☐ PharmD ☐ PhD ☐ PT ☐ RN ☐ Other _____

Title _____ Company _____ Address 1 _____ Address 2 _____

City _____ State/Province _____ ZIP/Postal Code _____ Country _____

Email _____ Work Phone _____ Mobile Phone _____ Fax _____

Wound Care Certified? ☐ No ☐ Yes _____
Additional Degrees/Certifications *(i.e. PCWC, CWS, etc.)*

CLINICAL SPECIALTY

☐ Burns/Trauma Medicine ☐ Dermatology ☐ Family Practice ☐ Geriatric Medicine

☐ Hyperbaric Medicine ☐ Internal Medicine ☐ Nursing ☐ Occupational/Physical Therapy

☐ Pathology ☐ Pedorthic ☐ Plastic Surgery ☐ Podiatry

☐ Surgery - General ☐ Vascular Surgery ☐ Wounds - General ☐ Other _____

Are you willing to serve on a Committee? If yes, select preference(s):

☐ Education ☐ Marketing ☐ Membership ☐ Policy/Legislative ☐ Quality Measures ☐ Credentialing

MEMBERSHIP LEVELS 1 YEAR

☐ Physician Member $195

☐ Non-Physician Member $135

☐ Fellow/Student/Resident $25

☐ Retired..... $65

REFERRED BY: _____

PAYMENT INFORMATION

☐ **Payment by Check**
Payable to: APWCA, a 501(c)(6) nonprofit organization

☐ **Payment by Credit Card**

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Card Number: _____

Exp. Date: _____

Security Code: _____

Cardholder Name: _____

Signature: _____

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