AID MEMBERSHIP FORM

Name: _____

E-mail Address: _____

Credential/Specialty: _____

Home Address: _____

_____

Work Address: _____

_____

Office Contact/E-mail: _____

_____

Business Telephone Number: _____

Website (if any): _____

Cell Phone Number: _____

Please check one of the following:

- □ Include my name in AID's online directory of independent doctors.*
- □ Keep my membership in AID confidential.

□ One-Year Doctor Membership -$500 (per member)
□ One-Year Retired Doctor/Medical Student Membership -$100 (per member)
□ One-Year Health Advocate/ Medical Student Membership -$100 (per member)
□ One-Year Health Law Attorney Membership -$500 (per member)

Please make checks payable to the Association of Independent Doctors, and send them with this application to the following address:

Association of Independent Doctors
400 N. New York Ave., Ste. 213
Winter Park, FL 32789

**With the exception of this listing in our online referral tool, AID will never share member names or contact information without member authorization.*