

Organization of Facial Plastic Surgery Assistants
American Academy of Facial Plastic and Reconstructive Surgery
OFPSA Membership Application Form

Name: _____
 Title: _____
 AAFPRS Sponsor Name: _____
 Practice Name: _____
 Practice Address: _____

 Practice Telephone: _____ Number of Staff: _____
 Practice Fax: _____
 E-mail*: _____ Number of Physicians: _____
 How Long in Position: _____

*Please provide an email address if possible, due to many correspondence are sent via email.

Categories of Membership:

- Individual- \$100**
- Office- \$150 (list below office members included in this membership)**

Members shall be a dues paying representative of an active member of the American Academy of Facial Plastic and Reconstructive Surgery who support the objective and purposes of the Organization. They shall enjoy all rights and privileges, duties, and obligations of membership in OFPSA.

Annual dues shall be paid by August of each year prior to the Annual Meeting. Checks should be made payable to American Academy of Facial Plastic Surgery and Reconstructive Surgery (AAFP RS) and sent to:

AAFP RS
 P.O. Box 759019
 Baltimore, MD 21275-9019
Credit card payments may be mailed to:
 310 S. Henry Street
 Alexandria, VA 22314
 or faxed to (703) 299-8898

METHOD OF PAYMENT (in U.S. dollars only)	
<input type="checkbox"/> Check enclosed (made out to the AAFPRS)	
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	
Card No. _____	
Exp. _____	Signature _____
Print Name on Card _____	