



**Organization of Facial Plastic Surgery Assistants  
American Academy of Facial Plastic and Reconstructive Surgery**

**OFPSA Membership Application and Dues Form  
January 1, 2018 – December 31, 2018**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 AAFPRS Sponsor Name: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 How long have you worked in your current position? \_\_\_\_\_  
 Number of practice staff: \_\_\_\_\_ Number of practice physicians: \_\_\_\_\_

**Categories of Membership:**

Office - \$180

*(Please list below office members and their \*individual e-mail address. They will be included in this membership)*

Name	Email Address

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. Checks should be made payable to American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS).

<p><b>METHOD OF PAYMENT (in U.S. dollars only)</b></p> <p><input type="checkbox"/> Check enclosed (made out to the AAFPRS)</p> <p><input type="checkbox"/> Visa    <input type="checkbox"/> MasterCard    <input type="checkbox"/> American Express</p> <p>Card No.: _____</p> <p>Exp: _____ Security Code: _____</p> <p>Name as it appears on the card: _____</p> <p>Signature: _____</p>
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**American Academy of Facial Plastic and Reconstructive Surgery**  
 P. O. Box 222772  
 Chantilly, VA 20153-2772

**Credit card payments by phone, please call**  
 Leigh A. McGuire at 703-299-9243 and provide the credit card information by phone.