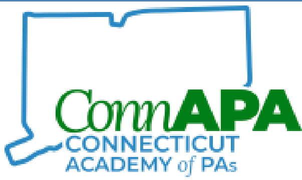

APPLICATION FOR GROUP MEMBERSHIP

Please send completed application form and payment to:
ConnAPA, P.O. Box 30, Bloomfield, CT 06002
For more information: contact the ConnAPA Office at 860-243-3977 or by emailing connapa@ssmgt.com.

GROUP INFORMATION		
Group/Department Representative Name:		
Organization:	Title:	Phone:
Address:		
City:	State:	ZIP Code:
Contact Phone:	Fax:	Contact Email:
BILLING INFORMATION		
Name:		
Address:		
City:	State:	ZIP Code:

PARTICIPATING FELLOW MEMBERS

All fields are required for each member. Group or individual payments will be accepted.

Name and Credentials:	**Home address:**		**Phone:**
			Email:
PA Program and Grad date (00/00 format):	**NCCPA #**	**AAPA #**	**Specialty:**
	Check or Credit Card #		**Expiration Date:**
Name and Credentials:	**Home address:**		**Phone:**
			Email:
PA Program and Grad date (00/00 format):	**NCCPA #**	**AAPA #**	**Specialty:**
	Check or Credit Card #		**Expiration Date:**
Name and Credentials:	**Home address:**		**Phone:**
			Email:
PA Program and Grad date (00/00 format):	**NCCPA #**	**AAPA #**	**Specialty:**
	Check or Credit Card #		**Expiration Date:**
Name and Credentials:	**Home address:**		**Phone:**
			Email:
PA Program and Grad date (00/00 format):	**NCCPA #**	**AAPA #**	**Specialty:**
	Check or Credit Card #		**Expiration Date:**
Name and Credentials:	**Home address:**		**Phone:**
			Email:
PA Program and Grad date (00/00 format):	**NCCPA #**	**AAPA #**	**Specialty:**
	Check or Credit Card #		**Expiration Date:**

Additional members can be added on reverse of this application

GROUP PAYMENT INFORMATION	
Check Enclosed # (Please make check payable to ConnAPA)	
Credit Card # (VISA, MC, AMEX, DISC)	**Exp. Date:**
Name on Card:	
Signature:	

A group is defined as 2 or more PAs in the same medical group, private office, or hospital department. To verify that your group qualifies for 50% participation, groups must attach to this application a list of all PAs in the practice/group.

I authorize the verification of the information provided on this form. I have read and understand the guidelines of ConnAPA group membership.

Signed: ____ Date: ____________________

PARTICIPATING FELLOW MEMBERS

Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA #	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA #	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA #	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA #	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA #	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA#	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA#	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA#	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA#	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA#	Specialty:
	Check or Credit Card #		Expiration Date:
Name and Credentials:	Home address:		Phone:
			Email:
PA Program and Grad date (00/00 format):	NCCPA #	AAPA#	Specialty:
	Check or Credit Card #		Expiration Date: