

# APWCA

## *American Professional Wound Care Association*

*A Professional Association for Wound Care and the Related Sciences*

853 Second Street Pike, Suite #A-1

Richboro, Pennsylvania 18954

Phone: 215-364-4100 Fax: 215-364-1146 E-mail: [wounds@apwca.org](mailto:wounds@apwca.org) [www.apwca.org](http://www.apwca.org)

Thank you for your interest in joining the APWCA. The Board of Directors believes you will find APWCA a worthwhile and refreshing Association to join and become active to the extent that your interest and schedule determines. Your membership in this dynamic, interactive Association is appreciated. Below are some guidelines to assist you in the application process. Should you have any additional questions, please do not hesitate to contact APWCA headquarters by phone or E-mail. Attached is an application that requires completion. Please note the following:

### 1. PLEASE COMPLETE THE APPLICATION AS FOLLOWS:

- a. **Please type or print neatly and legibly**
- b. E-mail address. Much of our communication is accomplished by E-mail. If you do not have E-mail personally, but know of an individual as a family member that has access to same, see if you can use that address and they can print out information and forward it to you as other members have done. Without E-Mail you still will receive the APWCA Newsletter *SYNERGY* twice yearly, but precludes receiving free APWCA E-Mail News updates about once monthly and Wound News Service that is available to our Association members only through E-mail
- c. Enclose remittance for membership fees made payable to “APWCA” in the amount of:  
\$185.00 for Physicians (MD, DO and DPM)  
\$135.00 Nurses and all non-physicians  
\$ 65.00 Students and residents. (Attach letter from school or hospital to verify status)
- d. **International members** are requested to submit membership fees in US dollars by charge cards, using *VISA, Master Card or American Express using proper conversion to US dollars*. Please do not use foreign check.
- e. If charging the membership fees attach charge information to include name exactly as it appears on the charge card, charge card number, expiration date, type of card as *Visa, Master Card, American Express (APWCA participates with these three cards.)* This information may be mailed in with application, faxed to the office or handled over the telephone. Do NOT E-Mail Charging information as the APWCA site is not secured. *International members should either charge using VISA, Master Card or American Express using proper conversion to US dollars.*
- f. **Sign and date the application**

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## APPLICATION FOR APWCA MEMBERSHIP

**Please Type or Print Clearly** and forward hard copy to office with ALL requested material listed on page 2

**NAME, (Including Degree):** \_\_\_\_\_.

**STREET ADDRESS:** \_\_\_\_\_.

**CITY :** \_\_\_\_\_.

**STATE:** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_ **COUNTRY** \_\_\_\_\_.

**PHONE NUMBER:** \_\_\_\_\_ **FAX** \_\_\_\_\_.

**E-MAIL (TYPE OR CLEARLY PRINT):** \_\_\_\_\_.

**DATE OF BIRTH :** \_\_\_\_\_

Note If you have access to E-Mail address through yourself or other please provide address as much communication is via E-Mail

**MEDICAL or PROFESSIONAL SCHOOL:** \_\_\_\_\_.

**STREET ADDRESS:** \_\_\_\_\_.

**CITY :** \_\_\_\_\_.

**STATE, ZIP CODE :** \_\_\_\_\_.

**DATE OF GRADUATION:** \_\_\_\_\_.

**STATE LICENSURE:** STATE \_\_\_\_\_.

EXPIRATION DATE \_\_\_\_\_.

STATE LICENSURE NUMBER: \_\_\_\_\_.

<b>TYPE OF MEMBERSHIP</b>		
<b>CIRCLE CATEGORY APPLICABLE</b>	<b>Not Board Certified</b>	<b>Board Certified</b>
Physicians: _____ MD, DO, DPM	<b>ASSOCIATE</b> Not Board Certified	<b>FELLOW</b> Board Certified in specialty or wound care or PhD
All other _____ Medical Professionals	<b>ASSOCIATE</b> Not Board Certified	<b>DIPLOMATE</b> Board Certified in specialty or in wound care

**SEE OTHER SIDE**

**Board Certified or Qualified. Please provide following qualifying board information**

NAME of BOARD: \_\_\_\_\_.

CIRCLE: CERTIFIED OR QUALIFIED: \_\_\_\_\_.

EXPIRATION DATE FOR CERTIFIED OR QUALIFIED BOARD STATUS: \_\_\_\_\_.

BOARD CERTIFICATION, CERTIFICATE NUMBER: \_\_\_\_\_.

**MEMBERSHIP FEE**

Submit membership fee as follows made payable to "APWCA"  
by check or charge card (VISA, Master Card or American Express)

1. \$185.00 for physicians (MD, DO, DPM)
2. \$135.00 for non-physicians (Nurses, Physical Therapists, PhDs, etc.)
3. \$ 65.00 for students and residents (Attach letter from school or hospital to verify status)
  
4. International members are requested to submit membership fees in US dollars  
by charge cards, please do not use foreign check.
5. If charging the membership fees attach charge information to include name exactly as it appears on the charge card, charge card number, expiration date, type of card as *Visa, Master Card, American Express (APWCA participates with these three cards.)* This information may be mailed in with application, faxed to the office or handled over the telephone. Do NOT E-Mail Charging information as the APWCA site is not secured. *International members should either charge using VISA, Master Card or American Express using proper conversion to US dollars.*
6. **Sign and date this application below**

The signature below indicates that I am aware of all of the information submitted with the application and that all of the information is true and without false representation. By joining the American Professional Wound Care Association, I also acknowledge that I have been involved in the treatment of patients who have had chronic wounds. It is for this reason that I request membership in the APWCA in order to participate in multidisciplinary education and enhance my knowledge in the treatment of these complex wounds.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_.

**SEE OTHER SIDE**