



# Application for Membership

Name \_\_\_\_\_

Degree \_\_\_\_\_

License Number \_\_\_\_\_

State \_\_\_\_\_ Date \_\_\_\_\_

## Select a Membership Category from the options below:

- Regular: Active \$350 per year  
MD, DO, ND, NMD, DDS, DMD, NP, PA who holds a valid license to practice his/her profession in the U.S.  
Regular, active membership applicants, please enclose application fee of \$25.00, and a photocopy of your current license. (If you wish to enclose your dues, no application fee is required.)
- AIH Senior Members  $\geq$  65 y/o Members in good standing in AIH for 20 yrs., still in active practice: \$275 per year
- AIH Senior Members  $\geq$  65 y/o Members in good standing in AIH for 20 yrs., retired: \$175 per year
- AIH Senior Members  $\geq$  65 y/o Retired not previously an AIH member for 20 years: \$200 per year
- In-Training Active \$200 per year  
MD, DO, ND, NMD, DDS, DMD, NP, PA who participates in a valid medical, surgical, or dental training program.  
Members in-training, please indicate the anticipated duration of your training and its location.
- Affiliate Member \$250 per year  
Pharmacologists and Pharmacists.
- Corresponding \$200 per year  
A licensed foreign physician  
Corresponding, (foreign) applicants, please include a copy of your license.
- Student \$50 per year  
A matriculant in good standing in an accredited school of medicine, osteopathy, naturopathy, dentistry, veterinary, pharmacology or pharmacist with an interest in homeotherapeutics.  
Student membership applications please include copy of student I.D. card.

Credit Card  Visa  MasterCard  Discover



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Card Number \_\_\_\_\_ Expires \_\_\_\_\_ / \_\_\_\_\_

Signature X \_\_\_\_\_

## Professional Information

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

## Home Information

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Please List Degrees \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you Board Certified?  Yes  No

Board of Certification \_\_\_\_\_

The AIH publishes a directory of our membership. Please indicate what of your office information should **not** be published. Your home information will not be published, but provided only to AIH members. I agree to having the above *office* information *except where indicated* published in the



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AIH *Directory of Members* and/or on the  AIH website.

Signature X \_\_\_\_\_

Applicants for Corresponding or Student membership may stop here after signing above.

Professional domestic applicants are asked to answer the following questions:

- Yes  No Are you prepared to practice homeotherapeutics in accordance with the AIH Standards of Practice?(see Standards)
- Yes  No Have you listed a physician reference?
- Yes  No Have you been convicted for fraud or a felony within the last five years? \*
- Yes  No Has any action, in any jurisdiction, been taken regarding your license to practice medicine within the last five years or extending to within the last five years? This includes actions involving revocation, suspension, limitation, probation, or any other sanctions or conditions imposed upon a license.\*
- Yes  No Have you been the subject of any disciplinary action by any medical society or hospital staff within the last five years? \*

Conviction for fraud or a felony, or actions involving revocations, suspension, limitation, probation, or any other sanctions or conditions imposed upon a license to practice medicine or disciplinary action by any medical society or hospital staff, after due notice and hearing, may result in censure, suspension, or expulsion of a direct member. The Health Care Quality Improvement Act requires professional societies to report certain professional review actions that adversely affect membership, including denial of membership, to the National Practitioner Data Bank.

Please list a professional reference with telephone number below:

Name \_\_\_\_\_

Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature X \_\_\_\_\_



# Application for Membership

To the best of my knowledge, I have answered the above questions fully and honestly. I agree to abide by the **By-Laws** of the American Institute of Homeopathy, to pay all dues, fees and assessments in a timely fashion, and to conduct my practice in an ethical manner.

Signature X \_\_\_\_\_

**Office Use Only:**

Date Received \_\_\_\_\_ License Verification \_\_\_\_\_  
Newsletter, 30 days \_\_\_\_\_ Journal \_\_\_\_\_  
Letter, Certificate, Membership Card \_\_\_\_\_  
Return Application to address below. Call with any questions.

**American Institute of Homeopathy**  
c/o George Guess MD DHt, Trustee  
909 Summit View Lane  
Charlottesville, VA 22903  
Telephone: (888) 445-9988