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 ≥ 65 y/o	Members in good standing in AIH for 20 yrs., still in active practice: $275 per year
☐	AIH Senior Members ≥ 65 y/o	Members in good standing in AIH for 20 yrs., retired: $175 per year
☐	AIH Senior Members ≥ 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.

Application for Membership

Credit Card ☐ Visa ☐ MasterCard ☐ Discover

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 _____

Application for Membership

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 Your home information will not be published, but provided only to AIH members.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

☐ 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 _____

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 Sandra M. Chase, MD, DHt, Trustee
10418 Whitehead St.
Fairfax,Virginia 22030
Telephone: (888) 445-9988