



PHYSICIAN ASSISTANT ACADEMY OF VERMONT

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PAAV Membership Application

Please provide an address you would prefer us to use for correspondence.

Name _____ Suffix(PA-C, Jr. III) _____
Affiliation _____
Department _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Fax Number _____
Email _____

AAPA Member Yes No
Training Program _____
Year Graduated _____ Practice Setting _____

ANNUAL DUES: Member \$55 Student Member \$15
Payment Method Check VISA Mastercard American Express
Credit Card #: _____ Exp. Date _____
Name on Credit Card _____
Signature _____
Street address and zip code that credit card statement is mailed to (for bank verification purposes) _____
