ASSOCIATION OF RINGSIDE PHYSICIANS

Membership Invoice

Name: _____ Suffix: _____

Address 1: _____

Address 2: _____

City: _____ State:_____ Postal Code: _____Country: _____

Phone: _____ Email: _____

ANNUAL MEMBERSHIP DUES:

❒ **Physician Member: $300.00**
Offered to any MD or DO

❒ **Medical Student/Resident Member: $50.00**
Offered to all medical students, or individuals in their internships or residencies.

❒ **Associate Member: $100.00**
Offered to Commission members and staff, attorneys.

❒ **Allied Healthcare Professional Member: $100.00**
Offered to physician assistants, EMT's, paramedics, nurses, nurse practitioners, athletic trainers, and chiropractors, and other paramedical personnel the board deems appropriate.

PAYMENT OPTIONS:
Join/Renew Online at www.RingsideARP.org

❒ Check # _____

❒ Credit Card Visa MasterCard Discover

Cardholder Name: _____

Credit Card Number: _____

Exp. Date: _____ CVV: _____

Signature: _____

Please send your payment to:
Association of Ringside Physicians · 2424 American Lane · Madison, WI 53704