



GAPI MEMBERSHIP APPLICATION FORM

FIRST NAME	
LAST NAME	
HOME ADDRESS	
CITY	STATE & ZIP
HOME #	CELL #
WORK #	FAX #
WORK ADDRESS	
WORK CITY	WORK STATE & ZIP
E MAIL	PREFERRED MAIL ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> WORK
MEDICAL SPECIALITY	
MEDICAL COLLEGE	
SPOUSE NAME	
IS SPOUSE PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
LIFE MEMBERSHIP IS \$ 500 FOR PHYSICIAN (INDIVIDUAL) LIFE MEMBERSHIP IS \$ 750 FOR PHYSICIAN COUPLE ANNUAL MEMBERSHIP IS \$ 50 PER YEAR PER PHYSICIAN PLEASE E-MAIL YOUR INFORMATION AS ATTACHMENT TO ANY OF THE GAPI OFFICER TO UPDATE YOUR DATABASE INFORMATION. MAIL YOUR CHECK OR CREDIT CARD INFORMATION PAYABLE TO GAPI AT C/O DR. DILIP PATEL, 1466 THREEPINE PLACE, LILBURN, GA 30047 or E-MAIL: dilippatel@pol.net NOTE:	