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Active/Inactive Member of National AAPI Yes/No

Life Membership Fee \$200.00 (Individual)

\$350.00 (Spouse if both MD)

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M / F

MD

Yes/No

Name of Children: _____

M / F

MD

Yes/No

Name of Children: _____

M / F

MD

Yes/No

I certify all above information is correct and subject to verification before granting me membership as per AAPIQLI bylaws (LINK TO Bylaws)

Signature: _____

Date: _____

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Date: _____

Nomination by AAPIQLI Member

Name: _____

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Approved by: _____

Yes/No

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Please mail the form to: 3 Parkway Drive, Roslyn Heights NY 11577 or email: ichhabra@leffertsmedical.com

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