American Association for Primary Care Endoscopy

Improving Health Through Primary Care EndoscopyTM

AAPCE
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672

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Your membership is good for 1 year after the date that you pay your membership dues. You will be notified for renewal before your membership expires. Your membership benefits will include: Membership in the only national endoscopy organization for primary care physicians, Networking with other like-minded primary care endoscopists, teachers, and researchers via an exclusive primary care endoscopy list serve, You will be supporting a national organization that is improving access to care through greater availability of competent primary care endoscopists and you will have access to CME specifically for primary care endoscopists.

Personal Information

First Name: _____ Last Name: _____

Street Address1: _____

Street Address2: _____

City: _____ State: _____

Zip Code: _____ Home Phone: _____

Country: _____

Date of Birth (mm/dd/yyyy): _____

Gender: ☐ Male ☐ Female

Ethnic Background (optional): ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ White/Anglo American ☐ Other

This is OPTIONAL and has no bearing or effect on a member's eligibility for membership or relationship with AAPCE. This information will be added to the member database profile.

Preferred Email Address:: _____

Your email address will be your username to login and your password will be emailed to you.

Business Information

Name of Institution/Private Practice: _____

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____

Zip Code: _____

Business Phone: _____ Fax: _____

Business Web Site (optional): _____

Preferred Mailing Address: ☐ Business ☐ Home

Professional Liability Insurance (optional): _____

Additional Annual Malpractice Premium for Endoscopy (if applicable): _____

Total Annual Malpractice Premium: _____

Military Provider/Public Health Service *(Federal Tort Claims Act)*: _____

Federally Qualified Health Center *(Federal Tort Claims Act)*: _____

Other: _____

Criteria for Membership

Medical School _____

Graduation Date (mm/yyyy): _____

Residency Specialty: _____

Institution: _____

Date of Completion (mm/yyyy): _____

Residents should indicate anticipated date of completion

Specialty Board Certification: _____

Residents should indicate anticipated specialty and certification date

Initial Year of Certification (yyy): _____

Recommended by one regular AAPCE member.
(If you do not know a current member of AAPCE but would still like to join, please contact us by email.)

Name: _____

List medical organizations in which you are a member: _____

Must maintain membership in a national organization representing the respective member's discipline or specialty field.

Endoscopic Experience/Commitment

Members must demonstrate commitment to endoscopic and/or gastrointestinal medicine in the primary care setting. If you do not perform endoscopy, please skip to the end of this section in order to indicate related publications/research/teaching experience.

Endoscopy that you perform (check all that apply):

- ☐ Flexible sigmoidoscopy
- ☐ Colonoscopy
- ☐ Snare polypectomy
- ☐ EGD
- ☐ Nonvariceal hemostasis
- ☐ Variceal hemostasis/banding
- ☐ Esophageal dilation, bougie
- ☐ Esophageal dilation, pneumatic
- ☐ PEG placement
- ☐ Esophagoscopy
- ☐ Capsule endoscopy

Other procedure(s) (nasolaryngoscopy, etc): _____

Endoscopy training (check all that apply):

- ☐ Residency
- ☐ Fellowship
- ☐ Formal procedure course*
- ☐ Preceptor, Family Medicine
- ☐ Preceptor, GI
- ☐ Preceptor, Surgeon

** Please indicate name and length of course in "Other" box here.* _____

Years performing endoscopy *(not including residency training)*: _____

Total number of procedures:

Flexible signmoidoscopy: _____

Colonoscopy: _____

EGD: _____

Capsule endoscopy: _____

Current Privileges (check all that apply): *Please indicate date that privileges where first established.*

- ☐ Flexible sigmoidoscopy Year first obtained (yyyy): _____
- ☐ Colonoscopy Year first obtained (yyyy): _____
- ☐ EGD Year first obtained (yyyy): _____
- ☐ Esophagoscopy Year first obtained (yyyy): _____
- ☐ Capsule endoscopy Year first obtained (yyyy): _____
- ☐ Conscious sedation Year first obtained (yyyy): _____

Other: _____

Location where endoscopy is performed (check all that apply):

- ☐ Hospital
- ☐ Surgical/Diagnostic center (free standing)
- ☐ Office

Other site(s): _____

Publications:

☐ GI Medicine

☐ Endoscopy

Other: _____

Research:

☐ GI Medicine

☐ Endoscopy

Other: _____

Teaching:

☐ GI Medicine

☐ Endoscopy

Other: _____

Resident Applicants Only:

Name of Residency Directory: _____

Email of Residency Directory: _____

Select your membership type.

☐ Regular Primary Care Membership | $125.00 ☐ Associate Membership | $125.00 ☐ Resident Membership | $25.00

Payment Information

Credit Card #: _____

Expiration Date (mm/yyyy): _____

CVV: _____

THANK YOU VERY MUCH!: *If you have any suggestions or comments regarding the application process, please let us know in the box below.*

How did you hear about AAPCE?