



Membership Application

Date: _____

Name: _____ Degree(s): _____

Board Certifications: _____ Medical Specialty: _____

Office Address: _____

City/State/Zip: _____

Office Phone: (____) _____ Fax: (____) _____

Back Line: (____) _____ Pager/ Cell: (____) _____

Email Address: _____

Home Address: _____

City/State/Zip: _____

Home Phone: (____) _____

Spouse: _____ if a Doctor, Specialty: _____

Does spouse want to become a member of CAPI? If so, please provide following information:

Office Address: _____

City/State/Zip: _____

Office Phone: (____) _____ Fax: (____) _____

Back Line: (____) _____ Pager/ Cell: (____) _____

Email Address: _____

Annual Membership Dues

_____ \$ 100.00 Regular Membership
(physician, dentist only)

Life Membership Dues (Single Payment)

_____ \$ 500.00 Regular Indiv. Life Membership
_____ \$ 750.00 Regular Joint Life Membership

Payment Information:

_____ Check (Make payable to CAPI)

_____ Cash

Please mail this form with check to, Atul Madan, 9025 Great Heron Circle, Orlando, FL 32836.