

NAEMSP DUES RENEWAL FORM



NAEMSP Executive Office
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E-mail: info-naemsp@goAMP.com

Full Name: _____

ID Number: _____

(If you don't know your ID we can look you up by your last name.)

Membership Type:

Physician \$325.00

Resident \$130.00

Fellow \$160.00

Professional \$160.00

Student \$100.00

International \$160.00

Preferred Mailing Address: _____

City, State, Zip: _____

Preferred Phone: _____

Preferred Fax: _____

Email: _____

Please check here if this is a change of address

Method of Payment:

Visa

MasterCard

American Express

Card Number: _____ Exp. Date: _____

Name on Card: _____

Signature: _____

Please check here if you have included a check.