



**Oregon Society of Physician Assistants**

*"extending health care"*

NEW MEMBER APPLICATION

Date \_\_\_\_\_

**Dues cover the membership year January 1 - December 31.**

**Applications received after July 1 and paid in full will be prorated 50% for the next year.**

NAME \_\_\_\_\_  
Last First MI DEGREE

Mailing Address \_\_\_\_\_  
Street County  
City State Zip

E-MAIL ADDRESS: \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work Pager

Occasionally we release your name and mailing address to organizations offering applicable CME courses. This is the ONLY time we release our list. Check here if you do NOT want this information released:

Business Address: SUPERVISING PHYSICIAN and TITLE: \_\_\_\_\_

BUSINESS/COMPANY/ORGANIZATION NAME (if applicable) \_\_\_\_\_

Street County  
City State Zip

PROGRAM ATTENDED: \_\_\_\_\_ PA \_\_ MD \_\_ NP \_\_ GRADUATION DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month/Year

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ AAPA Member? Yes \_\_\_\_ No \_\_\_\_ AAPA Membership No. \_\_\_\_\_

MAY WE USE YOUR NAME, MAILING ADDRESS & WORK NUMBER IN OUR PRINTED MEMBERSHIP DIRECTORY? YES \_\_\_\_ NO \_\_\_\_

OREGON PA POLITICAL ACTION COMMITTEE (PAC) CONTRIBUTION (1<sup>st</sup> \$50/indiv. tax deductible) \_\_\_\_\_

The OSPA newsletter, *Vital Signs*, is posted quarterly on our website. Yearly hard copy subscription rate: **\$10.00**

MEMBERSHIP CATEGORIES:	PA & SUPERVISING PHYSICIAN*	\$150.00	_____
	FELLOW	\$125.00	_____
	AFFILIATE*	\$125.00	_____
	OUT OF STATE OR MILITARY	\$55.00	_____
	FIRST YEAR IN OREGON	\$75.00	_____
	UNEMPLOYED	\$75.00	_____
	ASSOCIATE*	\$55.00	_____
	STUDENT**	\$ 25.00	_____

AMOUNT ENCLOSED.....\$ \_\_\_\_\_

PA & SUPERVISING PHYSICIAN: PA would be considered as either Fellow or Affiliate, based on AAPA membership; AFFILIATE: PA but not an AAPA member; ASSOCIATE: Non-physician assistant. \*\*STUDENT: Enrolled in or registered for a PA Program. Dues cover entire PA school enrollment, through the end of December after graduation.

A portion of dues may be deducted as an ordinary and necessary expense: contact the OSPA office for more information.

PLEASE RETURN APPLICATION WITH CHECK OR CREDIT CARD INFORMATION (SEE BACK) PAYABLE TO:

OREGON SOCIETY OF PHYSICIAN ASSISTANTS, P.O. BOX 2794, HILLSBORO, OR 97123

**Please Note: A \$20 fee will be charged on all returned checks.**

**OVER**

Thank you for taking the time to answer the questions below. Contact us if you have feedback on any areas.

Practice description: Academic Education/Administration Cardiothoracic Dermatology  
Emergency Medicine/Urgent Care Family Practice/Primary Care Internal Medicine  
Neurology/Neurosurgery Orthopedics/Orthopedic Surgery Student Surgery  
Other (please list)\_\_\_\_\_

Practice setting: Clinic Hospital Rural Urban Private Other (please list)\_\_\_\_\_

Population (e.g., 10,000, 100,000 etc.) \_\_\_\_\_

1. In what ways could the OSPA serve you better?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are you a member of the Oregon Medical Association? \_\_\_\_ Yes \_\_\_\_ No

If answer is No, please explain why: \_\_\_\_\_

\_\_\_\_\_

3. Are you a member of your county Medical Society? \_\_\_\_ Yes \_\_\_\_ No

If answer is No, please explain why: \_\_\_\_\_

\_\_\_\_\_

4. Have you had any difficulties or seen improvements in the last year in your practice concerning (circle all that are appropriate):

- Reimbursement from insurance companies, workers compensation, DOT exams, etc: Difficulties/Improved
- Compensation or benefits from employer: Difficulties/Improved
- Call schedules or definition of responsibilities: Difficulties/Improved
- Job satisfaction or inability to find the type of practice/location you desire: Difficulties/Improved
- Other Concerns: \_\_\_\_\_

5. Would you be interested in volunteering to assist in OSPA activities?

- |                            |                       |                              |
|----------------------------|-----------------------|------------------------------|
| ____ Governmental Affairs  | ____ PA Program       | ____ Web Page                |
| ____ Reimbursement         | ____ Public Relations | ____ Elections & Nominations |
| ____ CME                   | ____ Finance          | ____ Committee on Diversity  |
| ____ Membership            | ____ Newsletter       | ____ Awards Program          |
| ____ Other (specify) _____ |                       |                              |

6. Do you attend OSPA CME conferences? \_\_\_\_ Yes \_\_\_\_ No

If answer is No, please explain why: \_\_\_\_\_

\_\_\_\_\_

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CREDIT CARD INFORMATION (VISA/MC)

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_