

SUBMIT VIA EMAIL

MEMBERSHIP APPLICATION FORM

Note: Visiting physicians to the U.S. will not be involved in administering direct patient care.



I am interested in being a: Host Visitor Both

PERSONAL INFORMATION (AS IT APPEARS ON PASSPORT)

Last Name First Name

Sex: Male Female Date of Birth (MM/DD/YYYY)

Country of Citizenship Proof of Licensure

Address

Address (line 2)

City State Zip Code Country

Primary Telephone Number Check if mobile # Primary Email Address

Secondary Telephone Number Check if mobile # Secondary Email Address

EMERGENCY CONTACT INFORMATION

Last Name First Name

Relationship to you

Address

Address (line 2)

City State Zip Code Country

Primary Phone Number Primary Email Address

Secondary Phone Number Secondary Email Address

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SPECIAL CONSIDERATIONS

Please list below any special needs of which you would like to make APXA aware (e.g. dietary considerations, physical disabilities, etc.):

TERMS AND CONDITIONS

If I accept placement, I agree that:

1. I will take part in all aspects of the exchange program.
2. I will submit a completed APXA participant evaluation form at the completion of the visit (for both the *Visitor* and the *Host*).
3. My placement will be limited to the period specified. An extension request is subject to APXA review and my host's approval.
4. My placement may be terminated at any time during my exchange if I am found to have violated the laws of my host country.
5. As an APXA program participant, I will not be involved in administering direct patient care.
6. The *Host* is expected to accommodate the *Visitor* without any charge for room and board. The *Visitor* is expected to pay for travel and incidental expenses during the course of the exchange visit.

I acknowledge that all statements in this application are complete and accurate. I have read and understood the Legal Matters (posted on the APXA web site) and Terms and Conditions of undertaking an APXA program. **I am aware that it is my responsibility to obtain all visas, arrange travel, and conduct myself professionally during the course of my visit.**

Applicant's Signature

Date (MM/DD/YYYY)