ANNUAL MEMBERSHIP APPLICATION 2015-2016

In Official Relations with the American Public Health Association

Name (last, first): _____

Degree(s): _____ Title: _____

Agency/Organization: _____

Mailing Address 1: _____

Email address: _____

City: _____ State: _____ Zip: _____

Phone (Work): _____ Phone (Home; *optional*): _____

APHA Member: [ ] No [ ] Yes – Membership #_____

Membership Type: [ ] Regular Membership ($45) [ ] Student Membership ($10)

Is This Year's Caucus Membership: [ ] New or [ ] Renewal | Is Your Contact Info New/Changed? [ ] Yes

[ ] Yes, I would like to make a donation to *The Walter J. Lear Outstanding Student Award Fund*. $_____

[ ] Yes, I would like to make a donation to the LGBT Caucus general fund. $ _____

[ ] Yes, I would like to be contacted by email if the Caucus needs help or needs member involvement.

[ ] Check this box if you wish to have your membership with the LGBT Caucus kept confidential.
(Unless otherwise checked, your name may be released to APHA for Caucus recertification purposes)

Demographic & Other Personal Info (Strictly Confidential/For Internal Purposes Only)

Age: _____ *Race/Ethnicity:*_____

Gender: _____ *Sexual-Orientation:* _____

Occupation (Check One): [ ] Health Administration [ ] Gov't Employee (e.g., HHS, CDC) [ ] Nurse [ ] Physician [ ] Non-Profit [ ] Researcher/Professor [ ] Student (Undergrad) [ ] Student (Graduate) [ ] PhD Candidate [ ] Allied Health (e.g., Physician Assistant [ ] PT/OT [ ] Other _____

Research/Work Interests: _____

[ ] I am NOT attending the Annual Meeting - Please mail completed application w/ payment to:

LGBTC, c/o Allegra R. Gordon
Boston Children's Hospital
Division of Adolescent Medicine
300 Longwood Ave. (AU-Box 17, BCH 3189)
Boston, MA 02115