



AAAEM Membership Application

Name: _____ Date _____

Title: _____

Employer: _____

University Affiliation (If Different from Employer) _____

Do you have an Emergency Medicine Residency Program? Yes No

Hospital or Hospital System (If Different from Employer) _____

Email Address: _____

Phone: _____

Mailing Address:

Address Line 1: _____

Address Line 2: _____

City, State, Zip: _____

Name of Department Chairperson: _____

Please email your application to the Membership Committee Chair:

Kain Robbins: krobbins@hmc.psu.edu

717-531-0003 ext. 287436