Anesthesia Practice Administrators & Executives (AAE) Application

*Required fields—applications will not be accepted if left blank

(Please print or type)

Name:_____ Date:_____
Full Legal Name

*Title:_____ Credentials:_____

*Date of Birth:_____ Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female
MM/DD/YY

*Business Name:_____ Department: _____

*Address:_____ Is this your primary address: ☐ Yes ☐ No

*City:_____ *State:_____ *ZIP:_____ *Country:_____

Home Address:_____

City:_____ State:_____ ZIP:_____ Country:_____

*Email:_____ ☐ Personal ☐ Work

*Work Tel:_____ Personal Tel:_____ ☐ Home ☐ Cell

☐ I agree with the "Guidelines for the Ethical Practice of Anesthesiology" and subscribe to the "Anesthesia Care Team" statement, available at asahq.org/agreement.

Applicant's Signature: _____ **Date:** _____

Physician Endorsement (Active ASA member)

Name: _____ **ASA Active Member ID #:** _____

ASA Active Member Signature: _____ **Date:** _____

By providing name and signature, I am supporting this applicant and attesting to their eligibility for ASA AAE membership.

Payment Method

Only non-physicians can be Anesthesia Practice Administrator and Executive (AA-E) members. Physician anesthesiologists must join as Active members, regardless of the role or position they hold at their organization. Physicians who are not anesthesiologists, must join as Affiliate members.

Note: Group physician roster may be sent to AAEmembership@asahq.org. Reference membership application submission date.

☐ $0 Annual Dues
$0—if 90% or more of a group's physician anesthesiologists are ASA Active members in good standing AND all members will be on a single group bill.

ASA Group Bill ID Number: _____

☐ $258 Annual Dues
$258—if less than 90% of a group's physician anesthesiologists are ASA Active members in good standing, OR the group does not participate in group dues billing.

☐ American Express ☐ MasterCard ☐ VISA ☐ Check (*Payable to American Society of Anesthesiologists*)
If paying by credit card, your card will be charged upon approval of your application.

Total Amount:_____ Name on Card:_____

Credit Card Number:_____ Expiration Date:_____ Card ID:_____

Signature:_____

Mail payment and completed form to:
American Society of Anesthesiologists
Attn: Accounting
1061 American Lane
Schaumburg, IL 60173-4973
Or fax to: Attn: Membership (847) 825-1692