



**Association of Ringside Physicians
2017 Membership Invoice**

Name: _____ Suffix: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Annual Membership Dues:

Physician Member: \$150.00

Open to any MD or DO.

Medical Student/Resident Member: \$50.00

Open to all medical students, or individuals in their internships or residencies.

Associate Member: \$75.00

Commission members, staff, attorneys, physician assistants, EMT's, athletic trainers, and other medical personnel.

Total Amount Enclosed \$_____

PAYMENT OPTIONS:

Join / Renew Online at www.RingsideARP.org

_____ Check Enclosed

Please send your payment to:

**Association of Ringside Physicians
2424 American Lane
Madison, WI 53704**