

**South Asian Public Health Association: Membership Form (2006)**

*Please provide the following information (questions in bold with an asterisk are required fields).*

**I. Membership Information (please mark with x)**

- 1. Membership Category\*:**  Listserv-only  
 Student Member (\$25)  
 General Member (\$50)  
 Sponsor/Benefactor Member (>\$500)

*[If you selected the Student Member, please fill out the verification section at the end of the Membership Form. Thank You.]*

- 2. Will you be submitting this form via:**  on-line  mail

**II. General Information**

**1. First Name\*:** \_\_\_\_\_ **2. Middle Name/Initial:** \_\_\_\_\_

**3. Last Name\*:** \_\_\_\_\_

**4. Mailing Address:** \_\_\_\_\_

**5. City:** \_\_\_\_\_ **6. State:** \_\_\_\_\_ **7. Zip Code:** \_\_\_\_\_

**8. Phone (Mobile/Home):** \_\_\_\_\_

**9. Highest level of education:**

- |  |  |
|--|--|
| <input type="checkbox"/> High School/GED       | <input type="checkbox"/> MD                        |
| <input type="checkbox"/> BA/BS                 | <input type="checkbox"/> DrPH/PhD in Public Health |
| <input type="checkbox"/> MPH                   | <input type="checkbox"/> Other PhD: _____          |
| <input type="checkbox"/> Other Master's: _____ | <input type="checkbox"/> Other: _____              |

**10. Organization (Professional and/or Academic):** \_\_\_\_\_

**11. Title:** \_\_\_\_\_

*[If Student, please specify level (e.g. "Doctoral Student in Public Health")]*

**12. Email Address (for SAPHA correspondences)\*:** \_\_\_\_\_

**13. Area(s) of Interest (please identify up to 3 areas):**

- |   |  |
|---|--|
| <input type="checkbox"/> <a href="#">Activism/Community Organizing Issues</a> | <input type="checkbox"/> <a href="#">South Asian American Health Issues</a>      |
| <input type="checkbox"/> Alternative/Complementary Medicine                   | <input type="checkbox"/> South Asian Gay/Lesbian/Transgender                     |
| <input type="checkbox"/> <a href="#">Cancer Outreach/Prevention Issues</a>    | <input type="checkbox"/> <a href="#">South Asian International Health Issues</a> |
| <input type="checkbox"/> <a href="#">Cardiovascular/diabetes Issues</a>       | <input type="checkbox"/> Substance Abuse   |
| <input type="checkbox"/> <a href="#">Cultural Competency Issues</a>           | <input type="checkbox"/> Women's Health Issues                                   |
| <input type="checkbox"/> <a href="#">Domestic/Intimate Partner Violence</a>   | <input type="checkbox"/> Youth Health Issues                                     |
| <input type="checkbox"/> Elderly Care   | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> <a href="#">Environmental Health Issues</a>          |  |
| <input type="checkbox"/> Health Concerns                                      |  |
| <input type="checkbox"/> <a href="#">Health Policy/Advocacy Issues</a>        |  |
| <input type="checkbox"/> <a href="#">HIV Issues</a>                           |  |
| <input type="checkbox"/> <a href="#">Infectious disease Issues</a>            |  |
| <input type="checkbox"/> Mental Health  |  |
| <input type="checkbox"/> Nutrition  |  |
| <input type="checkbox"/> <a href="#">Occupational Health Issues</a>           |  |
| <input type="checkbox"/> <a href="#">Reproductive Health Issues</a>           |  |

14. Language skills: \_\_\_\_\_

15. Please provide a brief (3-6 sentences) description of your relevant professional experiences.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**16. Disclosure\*:** Would you like other SAPHA members to have access to your membership profile which will be created based on the information you have provided on this form?

- Yes  
 No

**17. Brown Paper:** Would you like a copy of the Brown Paper (while supplies last for Student, General and Sponsor/Benefactor categories only)?

- Yes  
 No

***III. Verification of Student Membership Status***

*For Students:*

1. Name of College/University\* \_\_\_\_\_  
2. City\* \_\_\_\_\_ 3. State\* \_\_\_\_\_  
4. Registrar's Phone Number\* \_\_\_\_\_  
5. Expected Graduation Date\* \_\_\_\_\_

*For Special Public Health Professionals:*

1. Name of employer\*(if any) \_\_\_\_\_  
2. Address\* \_\_\_\_\_  
3. City\* \_\_\_\_\_ 4. State\* \_\_\_\_\_ 5. Zip Code\* \_\_\_\_\_  
6. Contact Person\* \_\_\_\_\_  
7. Phone Number/Email address\* \_\_\_\_\_

**Mail to: SAPHA Membership  
48411 Antique Road  
Canton, MI 48187  
Checks should be made payable to South Asian Public Health Association.**