Delaware Academy of Physician Assistants - Group Membership Discount

Group Discount

Spread the benefits of joining DAPA with your colleagues. Any group that has the majority (90%) of their PAs join at the same time will receive a reduced rate of $90 a year. Payment is in the form of 1 check or PayPal transaction. Your DAPA membership gets you access to our employment portal, reduced price CME conferences, PA events, volunteer opportunities, and dinner events. Our dues allow DAPA to continue to serve the best interests of our patients and the PAs in the state of Delaware. We offer this 10% discount to encourage membership.

Group Enrollment Application

To qualify for discount, all physician assistants in your group must be members. Please provide the names and contact of all of the physician assistants in your group, both for verification and to give them membership.

Main Contact: _____
Group Name: _____
Mailing Address: _____
City_____State _____ Zip _____
Contact Telephone #: _____
Email: _____

For each Physician Assistant:

Physician Assistant #1

Name: First_____ Last _____
Mailing Address:_____
City_____State_____Zip: _____
Email: _____
DE License: Yes___No ____
AAPA Member: Yes___No ____

Make check payable and send to the:

"Delaware Academy of Physician Assistants"
Suite L10
4765 Ogletown Stanton Road
Newark, DE 19713

Membership Total:
(# of PAs) x 100 x .90 = total payment

…..more PA registrations on next page:

Physician Assistant #___

Name: First____________________ Last ______________________________
Mailing Address:________________________
City_______________State______Zip: _________________
Email: ______________________________
DE License: Yes___No ____
AAPA Member: Yes___No ____

Physician Assistant #___

Name: First____________________ Last ______________________________
Mailing Address:________________________
City_______________State______Zip: _________________
Email: ______________________________
DE License: Yes___No ____
AAPA Member: Yes___No ____

Physician Assistant #___

Name: First____________________ Last ______________________________
Mailing Address:________________________
City_______________State______Zip: _________________
Email: ______________________________
DE License: Yes___No ____
AAPA Member: Yes___No ____

Physician Assistant #___

Name: First____________________ Last ______________________________
Mailing Address:________________________
City_______________State______Zip: _________________
Email: ______________________________
DE License: Yes___No ____
AAPA Member: Yes___No ____

Physician Assistant #___

Name: First____________________ Last ______________________________
Mailing Address:________________________
City_______________State______Zip: _________________
Email: ______________________________
DE License: Yes___No ____
AAPA Member: Yes___No ____

Physician Assistant #___

Name: First____________________ Last ______________________________
Mailing Address:________________________
City_______________State______Zip: _________________
Email: ______________________________
DE License: Yes___No ____
AAPA Member: Yes___No ____

….For More PAs, make additional copies of this page