MISSOURI ACADEMY OF FAMILY PHYSICIANS

VOLUNTEER FORM

Today's Date: _____

Name:_____MD_____DO_____ AAFP ID:_____

Address:_____
Phone:_____ Fax:_____ Email:_____

Thank you so much for your interest in the MAFP. This form may be used to indicate your interest in one of our Commissions and also to indicate your interest in other volunteer activities. Please select your MAFP Commission preference and rank them accordingly ("1" being most preferred).

Education Commission is responsible for conducting all of the educational and research programs of the Academy, as well as encouraging and assisting in all resident and student related activities in Missouri.	☐
Membership Commission shall be charged with the recruitment and maintenance of qualified members of this Academy.	☐
Government Affairs Commission shall investigate and/or initiate methods of improving the health and well-being of the citizens of Missouri, representing the interests of family physicians and strengthening the specialty of family medicine, including encouraging the passage of laws to that end. This Commission will also have the responsibility for evaluating and initiating changes in the by-laws.	☐
Communications Commission is responsible for any publications, public relations efforts and communication with the news media regarding public relations efforts. The Communications Commission does not speak for the organization or represent the Board to the media.	☐
Other:_____	

First Commission Choice: (Please indicate any related background/expertise related to your first choice of commissions above)

Are you willing to serve on any commission to which you may be appointed? ☐ Yes ☐ No

Second Commission Choice: (Please indicate any related background/expertise related to your second choice of commissions above)

Periodically, MAFP receives requests seeking representatives for statewide coalitions and task force/committees. The information below will aid MAFP in developing a list for future use.

Please indicate your special interest, background, and/or expertise for additional volunteer opportunities.

Would you be willing to testify on legislation relating to your special interests? ☐ Yes ☐ No

Please describe your current professional position or practice circumstance. Check all that apply and provide any additional information that you feel would be helpful for MAFP to know.

☐ **solo practice** ☐ **academic** ☐ **currently in training**

☐ **administrative** ☐ **multi-specialty group**

☐ **small family medicine group practice (# in group):**

☐ **urban** ☐ **rural** ☐ **inner city**

☐ **employee of health care system (name):**

other (describe):

Any Additional training?	

Check all that apply:

☐ Currently licensed to practice in Missouri

☐ ABFM Board certified (date of last certification)

☐ AOA Board certified (date of last certification)

Please list any other AAFP or Chapter Offices you have held or Commissions you have served on:

Please list any other Medical Society affiliations / Professional activities:

Thanks again for your interest.
Please email the completed form to the MAFP at
722 West High Street Jefferson City, MO 65101-1526
or fax to 573-635-0148