Institutional New Member Form

Association of University Professors of Neurology

Thank you for your interest in joining AUPN! All membership category positions listed below are covered by the AUPN annual dues and therefore are entitled to all AUPN benefits. Please complete the below and remit to neuro@aupn.org. If there is not an individual in a specific role, please leave blank. Please contact neuro@aupn.org with questions.

Institution Contact Information:

Institution Name:

Institution Address:

City: State: Zip:

Phone Number: Fax:

Neurology Department Chair *(billing contact)*

Name:
(first, last)

Nickname:
(if applicable)

Suffix:
(MD, PhD, etc.)

Phone:
(if different than above)

Email:

Residency Program Director

Name:
(first, last)

Nickname:
(if applicable)

Suffix:
(MD, PhD, etc.)

Email:

Clerkship Director

Name:
(first, last)

Nickname:
(if applicable)

Suffix:
(MD, PhD, etc.)

Email:

Child Neurology Residency Program Director

Name:
(first, last)

Nickname:
(if applicable)

Suffix:
(MD, PhD, etc.)

Email:

Research Program Director

Name:
(first, last)

Nickname:
(if applicable)

Suffix:
(MD, PhD, etc.)

Email: