FACIALPAIN ASSOCIATION

MEMBERSHIP CONNECTS YOU WITH 35,000 PATIENTS

Signature Professional Membership $2,000

- Recognition of support:
  - with banner heading, contact information and link to Institution's site on FPA website
  - with photo and list of each individual physician within organization who is active in TN and related face pain treatment
  - in bi-annual emails to FPA Constituents
  - at the National Conference
  - on social media
  - in the *FPA Quarterly Journal*
  - in Annual Report
  - prominently displayed at the Gainesville Headquarters office
  - Annual Certificate of Membership
- Opportunity for article publication and webinar hosting
- Annual Subscription to the FPA Quarterly Journal and discounted advertising rates
- Free Patient Educational Pamphlets

Professional Membership $350

- Recognition of support:
  - on the FPA website with photograph and link to your site
  - in Annual Report
  - Annual Certificate of Membership
- Opportunity for article publication and webinar hosting
- Annual Subscription to the FPA Quarterly Journal
- Free Patient Educational Pamphlets

Want to engage patients further? Contact us for exclusive sponsorship opportunities!

800-923-3608

JOIN HERE or at facepain.org

Medical Professional Information

Name ____________________

Address ____________________

____

Telephone ____________________

Email ____________________

Please fill in a *Medical Professional Profile Form* and return via email with a head shot and a logo (if applicable).
An EPS or PDF vector logo preferred. JPEG is acceptable.

Mail to: The Facial Pain Association
22 SE Fifth Avenue, Suite D
Gainesville FL 32601

Payment

____ Credit card ____ Please bill me

____ Check made payable to the Facial Pain Association

____ Please automatically renew my membership upon expiration (12 months)

Credit Card Information

____ Visa ____ MC ____ AmEx ____ Discover

Card/Account # ____________________

Expiration ____________ Amount ____________

Name on Card ____________________

Billing Address ____________________

____

Signature ____________________

May2019

FACIALPAIN ASSOCIATION

PROFESSIONAL MEMBER PROFILE FORM

Professional Member Information

Name ____________________

Title ____________________

Position ____________________

Address ____________________

Telephone ____________________ Fax ____________________

Email ____________________

Web Address ____________________

Clinical Background

Medical School ____________________

Internship ____________________

Residency ____________________

Fellowship(s) ____________________

Board Certification ____________________

Face Pain Treatments provided ____________________

____

____

____

____

____

____

Please email the completed "Physician Profile Form" and a head shot and logo, if applicable. For the logo an EPS or PDF vector logo preferred. JPEG is acceptable.

Email completed form and physician photo to:

Amy Turner
aturner@tna-support.orgg

Questions please call
800-923-3608

05-2019