



**AAE Mission Statement**

The Association of Asthma Educators is the premier inter-professional organization striving for excellence to raise the competency of diverse individuals who educate patients and families living with asthma.

**AAE Vision Statement**

*The shared vision of the Association of Asthma Educators is to be:*

- AAE is the premier provider of evidence-based asthma education.
- AAE advocates for patients with asthma and their families.
- AAE advocates for underserved and minority populations, and addresses disparities in asthma outcomes.
- AAE improves asthma management and education outcomes.

**Application for membership (please print clearly or attach business card)**

Last Name	First Name	Middle Initial	Credentials
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Address (home) \_\_\_\_\_

City	State	Zip
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Phone	Fax	Home E-mail Address
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Place of Employment \_\_\_\_\_

Address (work) \_\_\_\_\_

City	State	Zip
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Phone	Fax	Work E-mail Address
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**Where do you want to receive mail?**       Home       Work

Preference for Name Tags, etc. \_\_\_\_\_

Current Position/Title _____	First Name	Last Name	Credentials
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Certification \_\_\_\_\_ Expiration Date \_\_\_\_\_

- Individual Membership** – Open to Licensed Health Care Professionals. Application/annual membership fee: \$70
- Associate Membership** – Open to Affiliated Health Care Professionals (Non-Licensed). Application/annual membership fee: \$50
- Student Membership** – Application/annual membership fee: \$50 (*Proof of current enrollment required.*)

*Checks should be payable to the Association of Asthma Educators or to AAE.*

Please check here if you DO NOT wish your name to be released to organizations requesting a list of our members.

**Method of Payment:**

- Check       Credit Card:       Visa       MasterCard       American Express

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Total Enclosed/Charged \$: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**How did you hear about AAE?**  Colleague  AAE Conference  AAE Newsletter  
 AAE National Asthma Educator Certification Review Course  Web Search  
 Other Allied Health Conference (*Please specify*): \_\_\_\_\_

**Tell us about your clinical practice ?** Please check one under each heading:

PATIENT AGE	PRACTICE SETTING	SPECIALTY
<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Community-based	<input type="checkbox"/> Allergy
<input type="checkbox"/> Adults	<input type="checkbox"/> Outpatient office	<input type="checkbox"/> Pulmonary
<input type="checkbox"/> Geriatric	<input type="checkbox"/> School	<input type="checkbox"/> Non-clinical _____
<input type="checkbox"/> Family	<input type="checkbox"/> Primary care	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Hospital inpatient	
	<input type="checkbox"/> University/academic	
	<input type="checkbox"/> Military	
	<input type="checkbox"/> Other	

**How long have you been an asthma educator? (check one)**

- <one year  5 to 10 years  
 1 to 3 years  10 to 20 years  
 3 to 5 years  > 20 years

**How many asthma education programs do you present each year? (check one)**

- none  3 to 10 per year  
 1 to 3 per year  >10 per year

**Do you have prescriptive authority?** (check one)  Yes  No

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**CERTIFICATIONS AND DESIGNATIONS: (please check all that apply)**

<input type="checkbox"/> AANP	<input type="checkbox"/> CAI	<input type="checkbox"/> CPPA	<input type="checkbox"/> MBA	<input type="checkbox"/> PharmD
<input type="checkbox"/> AAS	<input type="checkbox"/> CCM	<input type="checkbox"/> CPUR	<input type="checkbox"/> MD	<input type="checkbox"/> Pharmaceutical Rep
<input type="checkbox"/> ACLS	<input type="checkbox"/> CCNS	<input type="checkbox"/> CRC	<input type="checkbox"/> MEd	<input type="checkbox"/> PhD
<input type="checkbox"/> AE-C	<input type="checkbox"/> CCRC	<input type="checkbox"/> CRT	<input type="checkbox"/> MFS	<input type="checkbox"/> PPS
<input type="checkbox"/> APRN	<input type="checkbox"/> CCRN	<input type="checkbox"/> CRTT	<input type="checkbox"/> MHA	<input type="checkbox"/> PT
<input type="checkbox"/> ASHP	<input type="checkbox"/> CDE	<input type="checkbox"/> CS	<input type="checkbox"/> MPA	<input type="checkbox"/> RCP
<input type="checkbox"/> Asthma Practitioner	<input type="checkbox"/> CDM	<input type="checkbox"/> CSM	<input type="checkbox"/> MPh	<input type="checkbox"/> RHIA
<input type="checkbox"/> BA	<input type="checkbox"/> CEN	<input type="checkbox"/> CSN	<input type="checkbox"/> MS	<input type="checkbox"/> RN
<input type="checkbox"/> BAN	<input type="checkbox"/> CGS	<input type="checkbox"/> CURN	<input type="checkbox"/> MSHA	<input type="checkbox"/> RNC
<input type="checkbox"/> BCPS	<input type="checkbox"/> CHES	<input type="checkbox"/> DNSC	<input type="checkbox"/> MSN	<input type="checkbox"/> RPFT
<input type="checkbox"/> BS	<input type="checkbox"/> CMC	<input type="checkbox"/> DSM	<input type="checkbox"/> MSW	<input type="checkbox"/> RPh
<input type="checkbox"/> BSN	<input type="checkbox"/> CNP	<input type="checkbox"/> EdD	<input type="checkbox"/> NARTC	<input type="checkbox"/> RRT
<input type="checkbox"/> BSPA	<input type="checkbox"/> CNS	<input type="checkbox"/> FAACVPR	<input type="checkbox"/> NIPCO	<input type="checkbox"/> RSCN
<input type="checkbox"/> BXC	<input type="checkbox"/> COHN	<input type="checkbox"/> LCSW	<input type="checkbox"/> PA	<input type="checkbox"/> TNCC
<input type="checkbox"/> CACP	<input type="checkbox"/> CPFT	<input type="checkbox"/> LPN	<input type="checkbox"/> PAC	<input type="checkbox"/> TNS
<input type="checkbox"/> CAE	<input type="checkbox"/> CPHQ	<input type="checkbox"/> MA	<input type="checkbox"/> PAL	<input type="checkbox"/> Other _____

**Please indicate which committee you would be interested in serving on:**

- Operations  Education  Strategic Planning  
 Finance  Public Relations

**Are you currently a member of (please check all that apply):**

- AAAAI  ACAA  ATS  AARC