family medicine
RESIDENCY CURRICULUM
resource

Please complete this form and include it with your check.

Section 1.

Residency Program Name: _____

Program Address: _____

City, State, ZIP Code: _____

ACGME Number: _____

Program Director Name: _____

Program Director Email: _____

Program Administrator Name: _____

Program Administrator Email: _____

Program Administrator Phone: _____

Section 2.

☐ NEW subscription - Please include a Username and Password to set up your account.

Username: _____ Password: _____

☐ RENEWAL

Section 3.

Please make check out to:
AFMRD
11400 Tomahawk Creek Parkway
Leawood, KS 66211

Cost per Year:

$1,200 - If your program has 12 or fewer total resident positions
$1,800 - If your program has 13 or more total resident positions

If you would like to pay by credit card, visit **https://www.fammedrcr.com/subscribe/**

Please note: At this time AFMRD does not accept ACH or Wire Transfers, nor do we take credit card information over the phone or via email.

If you have any questions concerning this form, contact Neil Robertson at nrobertson@aafp.org.