family medicine
RESIDENCY CURRICULUM
resource

Residency Program Name: ____

Program Address: ____

Program City, State, and Zip: ____

ACGME Number: ______________________ AOA Number: ____________________

Program Director Name: ____

Program Director Email: ____

Program Administrator Name: ____

Program Administrator Email: ____

Program Administrator Phone: ____

Please create a username and password. Each must be at least 8 characters.

New Subscription ☐ Renewal ☐

Username ______________________ Password ____________________________

Number of Resident Positions: _____ **12 or fewer positions - $1200 - More than 12 positions - $1800**

Check enclosed: ______ **Make check payable to "AFMRD"**

Credit Card Information

Name on the Credit Card: ____

Credit Card Type: ____________ Credit Card Number: ____________________________

Expiration Date: ___________ Security Code: ______

Signature: ____

Please mail payment to:
AFMRD
Residency Curriculum Resource
11400 Tomahawk Creek Parkway
Leawood, KS 66211
Questions? Call 913-906-6359