



American Association of University Professors

APPLICATION FOR MEMBERSHIP

Name _____
(Print) Last First Middle

Home Address (Needed to send *Academe*)

Street _____

City _____

State _____

Zip _____

E-Mail work _____

E-Mail home _____

Institution _____

Department _____

AAUP MEMBERSHIP CATEGORIES: (check one)

Tenure-track In residence

UHC-AAUP Constituency (needed for elections – check one)

medical/clinical dental medical/basic science

Signature _____

Date _____

Return form to: UHC-AAUP, 270 Farmington Avenue, Suite 364, Farmington, CT 06032

*Membership in UHC-AAUP automatically enrolls you in National AAUP