

# GENERAL MEMBERSHIP APPLICATION

To be used for General, Corresponding, and Affiliate members. Also available online at [www.aacap.org](http://www.aacap.org).

Last Name	First Name	Middle	Today's date
Hospital/Practice/Program/Company			
<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other: _____		Current Position	
Street Address			
City	State/Province	Zip/Postal Code	
Country (if not U.S.)	Telephone number	Fax number	
E-mail address			Date of birth

## Please indicate the membership category you are applying for:

Please note: Canadian and Mexican applicants who have received training in the U.S. have the choice of applying for General or Corresponding membership.

- General Member - \$550** (submit two professional activity verification forms and CAP training certification; training certification can be a copy your ABPN board certificate or a completed training verification form).  
Available to physicians who have been certified in child and adolescent psychiatry, or have completed training in an accredited child and adolescent psychiatry training program, and have completed general psychiatry training.
- Affiliate Member - \$450** (submit two professional activity verification forms).  
Available to any physician who is not eligible for General membership but is making contributions to the field of child and adolescent psychiatry.
- Corresponding Member - \$350** (submit two professional activity verification forms).  
Available to any physician living outside of the United States who would otherwise qualify for election to membership in either of the above categories.

## Professional Education and Training Information

I am board certified (or hold a certificate for the international equivalent) in:

- General Psychiatry  Child Psychiatry  Adult Psychiatry  Pediatrics

## Medical School Information

School Name	Graduation Date	Medical License #	State	Exp. Date
School Street Address	City, State, Zip	Country	Graduation Date	

## Psychiatry Residency Information

Program Name	Name of Program Director	Program Type		
School Street Address	City, State, Zip	Country	Completion Date	

## Child and Adolescent Psychiatry Residency Information

Program Name	Name of Program Director			
School Street Address	City, State, Zip	Country	Completion Date	

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Have you ever been found at fault by any medical board or professional ethics review committee, or are you now under investigation by any such group?

- Yes (if yes, please submit an explanation)       No

I understand that my application will be reviewed by the Membership Committee and my regional organization. I understand that the organization may make inquiries about my professional training and practices if deemed necessary. I understand that the organization is not obligated to offer membership on the basis of this application.

I have read the AACAP Bylaws and Code of Ethics and agree to abide by them. If accepted, I pledge to abide by the regulations of the AACAP as well as to high standards of ethical practice.

I affirm that the information on this application is true.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Regional Organization Membership - General Members Only

Dual membership in a regional organization is required per the Bylaws and any associated dues should be included with your enclosed payment for annual membership fees. Assignment to a regional organization should be based on the locality of practice. Please select a regional child and adolescent psychiatry organization.

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> AK-Alaska*                   | <input type="checkbox"/> FL-North Central Florida \$20 | <input type="checkbox"/> ME-Maine \$100           | <input type="checkbox"/> NY-New York Capital \$40        | <input type="checkbox"/> PR-Puerto Rico \$50       |
| <input type="checkbox"/> AL-Alabama \$25              | <input type="checkbox"/> FL-South Florida \$50         | <input type="checkbox"/> MI-Michigan \$110        | <input type="checkbox"/> NY-New York City \$100          | <input type="checkbox"/> RI-Rhode Island \$100     |
| <input type="checkbox"/> AR-Arkansas \$40             | <input type="checkbox"/> FL-Tampa Bay \$15             | <input type="checkbox"/> MN-Minnesota \$100       | <input type="checkbox"/> NY-New York Western \$50        | <input type="checkbox"/> SC-South Carolina \$50    |
| <input type="checkbox"/> AZ-Arizona \$50              | <input type="checkbox"/> GA-Georgia \$75               | <input type="checkbox"/> MO-St. Louis \$50        | <input type="checkbox"/> OH-Cincinnati \$80              | <input type="checkbox"/> SD-South Dakota           |
| <input type="checkbox"/> CA-Central California \$195  | <input type="checkbox"/> HI-Hawaii \$100               | <input type="checkbox"/> MS-Mississippi \$35      | <input type="checkbox"/> OH-Northeast Ohio \$75          | <input type="checkbox"/> TN-Tennessee \$20         |
| <input type="checkbox"/> CA-Northern California \$230 | <input type="checkbox"/> IL-Illinois \$120             | <input type="checkbox"/> MT-Montana Big Sky \$150 | <input type="checkbox"/> OH-Northwest Ohio*              | <input type="checkbox"/> TX-Texas*                 |
| <input type="checkbox"/> CA-San Diego \$250           | <input type="checkbox"/> IN-Indiana \$40               | <input type="checkbox"/> NE-Nebraska \$50         | <input type="checkbox"/> OH-Ohio Central \$100           | <input type="checkbox"/> UT-Intermountain \$57     |
| <input type="checkbox"/> CA-Southern California \$230 | <input type="checkbox"/> KS-Kansas \$50                | <input type="checkbox"/> NC-North Carolina \$50   | <input type="checkbox"/> OK-Oklahoma \$75                | <input type="checkbox"/> VA-Virginia \$50          |
| <input type="checkbox"/> CO-Colorado \$170            | <input type="checkbox"/> KY-Kentucky \$45              | <input type="checkbox"/> ND-North Dakota          | <input type="checkbox"/> OR-Oregon \$100                 | <input type="checkbox"/> VT-Vermont \$125          |
| <input type="checkbox"/> CT-Connecticut \$160         | <input type="checkbox"/> LA-Louisiana \$30             | <input type="checkbox"/> NJ-New Jersey \$75       | <input type="checkbox"/> PA/NJ-Eastern PA/South NJ \$100 | <input type="checkbox"/> WA-Washington State \$100 |
| <input type="checkbox"/> DC-Greater Washington \$170  | <input type="checkbox"/> MA-New England*               | <input type="checkbox"/> NM-New Mexico \$35       | <input type="checkbox"/> PA-Central Pennsylvania \$40    | <input type="checkbox"/> WI-Wisconsin \$75         |
| <input type="checkbox"/> DE-Delaware \$35             | <input type="checkbox"/> MD-Maryland \$100             | <input type="checkbox"/> NV-Nevada \$50           | <input type="checkbox"/> PA-Pittsburgh \$25              | <input type="checkbox"/> WY-Wyoming                |

Note: \*Regional organizations denoted with an asterisk identify a separate dues billing process. You will receive an invoice directly from the regional organization for your regional membership dues.

## Demographic Information

This information provided is necessary for some AACAP federal grants.

Gender  Female  Male

Ethnicity  Hispanic or Latino  Non-Hispanic or Latino

Race  American Indian or Alaska Native  
 Asian  
 African American or Black  
 Caucasian or White  
 Native Hawaiian or Other Pacific Islander  
 Other)

List language(s)  
\_\_\_\_\_  
\_\_\_\_\_

Are you a member of the American Medical Association?

Yes  No

Are you a member of the American Psychiatric Association?

Yes  No

Are you a member of the American Academy of Pediatrics?

Yes  No

## Payment Information

Please include a \$45 application processing fee in addition to your dues payment. Applications submitted after June 30 are only required to include half of the annual membership fee for the current year. Payment must be submitted by check, money order or credit card. Checks must be drawn from a U.S. bank. Send your completed application materials and dues payment to:

American Academy of Child & Adolescent Psychiatry, Attn: Member Services  
3615 Wisconsin Ave, N.W.  
Washington, DC 20016.

**Credit Card Payment** (Please note, we do not accept credit cards other than those below).

AMEX       MC       VISA

\_\_\_\_\_  
Total enclosed

\_\_\_\_\_  
CC #

\_\_\_\_\_  
Exp. date

\_\_\_\_\_  
Authorizing signature of cardholder

\_\_\_\_\_  
Date

You can fax your completed application with credit card payment to 202.464.0131.

**PLEASE FAX THE FRONT AND BACK OF THE APPLICATION AND ANY RELEVANT VERIFICATION FORMS.**

If you have questions regarding your application, please call 202.966.7300 ext. 2004 or email [membership@aacap.org](mailto:membership@aacap.org).