

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

PROCESSING APPLICATIONS

A number of members and applicants have been interested in the length of time an application takes for processing. The following is a step-by-step guide:

1. When an application is received it is checked for references and to see that all questions have been answered. We also make sure the application has been signed.
2. If the application is complete, an acknowledgment letter is mailed notifying applicant of his/her acceptance as a provisional member of the Academy.
3. The application is then forwarded to the appropriate regional organization for processing. When the regional organization has completed its review, it is forwarded to the Chair of the Membership Credentials Committee for final review. The Chair then forwards it to the AACAP Membership Department.
4. A ballot is mailed to the Executive Council with the recommendation of the Membership Chair. The Council votes on final acceptance of the applicants.
5. The Membership Department notifies both the applicant and the Regional Organization of final acceptance as a member.

WHY THE PROCESS MAY BE DELAYED:

- Applicant fails to complete all relevant sections.
- Applicant fails to answer the ethics question.
- Applicant fails to sign the application.
- Applicant has not included all references
- Applicant changes address without notifying the Central Office.
- Applicant has not paid application/membership fee.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

and

Regional Council of Child and Adolescent Psychiatry

DUAL APPLICATION FOR STUDENT MEMBERSHIP

*This application is a dual application for both AACAP and your Regional Organization of Child & Adolescent Psychiatry. We look forward to welcoming you as a member. When we receive your **completed** application and appropriate fees, you will be considered a provisional member of AACAP, as well as your regional council of child and adolescent psychiatry, and your benefits will be enacted.*

The Academy Bylaws outline the requirements for membership in the American Academy of Child and Adolescent Psychiatry.

Child & Adolescent Psychiatry Resident Membership is for physicians enrolled in training in Child and Adolescent Psychiatry in a program accredited by the Residency Review Committee in Psychiatry of the Accreditation Council for Graduate Medical Education. Child and Adolescent Resident Membership must be upgraded to Active Membership in the year training is completed.

Reference Required: Verification of enrollment in child and adolescent psychiatry training program from Child & Adolescent Training Director.

General Psychiatry Resident Membership is for physicians enrolled in training in General Psychiatry in a program accredited by the Residency Review Committee in Psychiatry of the Accreditation Council for Graduate Medical Education. General Resident membership must be upgraded to Child and Adolescent Trainee or Affiliate Membership in the year general training is completed.

Reference Required: Verification of enrollment in general psychiatry training program from General Training Director.

Medical Student Membership is for students enrolled in medical school.

Reference Required: Verification of enrollment in medical school program from Dean of Medical School.

Benefits of annual dues include a subscription to the monthly Journal and the bi-monthly Newsletter of AACAP, all membership mailings, reduced premiums for malpractice insurance coverage, and reduced fees for annual meetings, scientific institutes and annual reviews in child and adolescent psychiatry.

Child & Adolescent Resident\$60
General Resident\$60
Medical Student-0-

Please return completed application with appropriate membership fee to:

American Academy of Child and Adolescent Psychiatry

Attn: Membership Services

Box 96106, Washington, D.C. 20016

If you wish to pay by credit card please complete below:

Check one: VISA MC AMEX Account no.: _____

Expiration date: _____ Amount: _____

Signature: _____

If joining after June 30, you are only required to pay half of membership fee for the current year.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

(name of Regional Organization)

Regional Organization of Child and Adolescent Psychiatry

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MEMBERSHIP APPLICATION

1. Name: _____ Date of Application: _____
 Mailing Address: _____ Birth Date: _____
 _____ Telephone: _____
 _____ Fax Number: _____
 Email Address: _____

2a. Medical School (this section must be completed)

Dean		Date Started	Date Completed (anticipated)
School			
Address			

b. Residency training, please check one General Psychiatry
 Pediatrics

Training Director		Date Started	Date Completed (anticipated)
Program			
Address			

c. Child and Adolescent Psychiatry

Training Director		Date Started	Date Completed (anticipated)
Program			
Address			

3. Are you a member of the American Psychiatric Association?

Yes No (not required for AACAP membership)

Are you a member of the American Medical Association?

Yes No (not required for AACAP membership)

4. Have you ever been found at fault by any medical board or any professional ethics review committee, or are you now under investigation by any such group? Yes No (If yes, please explain)

I understand that the organization will make inquiries about my professional training and practices, either from professional societies, individual references, or any other individuals who may know my past or present professional activities, if such are deemed necessary. I also understand that the organization is not obligated to offer membership on the basis of this application.

I have read the Bylaws and Code of Ethics and agree to abide by them.

If accepted, I pledge myself to abide by the regulations of the Academy as well as to high standards of ethical practice.

I affirm that all the information in this application is true.

(Date) _____ (Signature) _____

INFORMATION REQUESTED IN THIS BOX IS FOR *STATISTICAL USE ONLY*

Information contained in this section will not be used as criteria for membership.

Date of Birth (___/___/___) Sex: Male Female
mo day yr

Ethnic Background: (check one)

Caucasian Native American Asian
 African American Hispanic Other _____

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016
(202) 966-7300

Verification Form

TO: Training Director, Dean or appropriate administrative staff

FROM: Beverly Sutton, M.D., Chair
Membership Credentials Committee

RE: _____
Applicant

DATE: _____

The above named person is applying for membership in the AACAP and must verify training. Please complete this form and *return it to the applicant*. Your assistance is appreciated.

Name of Training Institution _____

Type of Training _____

Date Started _____ Anticipated Completion Date _____

If training was not full-time, insert dates and percent of time of any part-time training.

_____ % From _____ To _____

If there were any interruptions in training, insert dates and reason for the interruption.

From _____ To _____

Reason _____

If training is in progress, is it continuing satisfactorily? Yes No

If NO, please explain _____

Signature _____ Name _____
(type or print)

Position _____ Date _____