GENERAL MEMBERSHIP APPLICATION

To be used for General, Corresponding, and Affiliate members. Also available online at www.aacap.org.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Last Name	First Name	Middle	Today's date

Hospital/Practice/Program/Company	
☐ M.D. ☐ D.O. ☐ 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 - $450 (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 - $395 (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 - $305 (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		

Psychiatry Residency Information

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

Child and Adolescent Psychiatry Residency Information

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

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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 Credentials Committee and my regional organizaton. 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.

- ☐ AK-Alaska*
- ☐ AL-Alabama $25
- ☐ AR-Arkansas $40
- ☐ AZ-Arizona $50
- ☐ CA-Central California $195
- ☐ CA-Northern California $230
- ☐ CA-San Diego $250
- ☐ CA-Southern California $230
- ☐ CO-Colorado $150
- ☐ CT-Connecticut $160
- ☐ DC-Greater Washington $170
- ☐ DE-Delaware $35
- ☐ FL-North Central Florida $20
- ☐ FL-South Florida $50
- ☐ FL-Tampa Bay $15
- ☐ GA-Georgia $75
- ☐ HI-Hawaii $100
- ☐ IL-Illinois $120
- ☐ IN-Indiana $40
- ☐ KS-Kansas $50
- ☐ KY-Kentucky $45
- ☐ LA-Louisiana $20
- ☐ MA-New England*
- ☐ MD-Maryland $100
- ☐ ME-Maine $100
- ☐ MI-Michigan $100
- ☐ MN-Minnesota $100
- ☐ MO-St. Louis $50
- ☐ MS-Mississippi $35
- ☐ MT-Montana Blue Sky $150
- ☐ NE-Nebraska $50
- ☐ NC-North Carolina $50
- ☐ ND-North Dakota
- ☐ NJ-New Jersey $75
- ☐ NM-New Mexico $35
- ☐ NV-Nevada
- ☐ NY-New York Capital $40
- ☐ NY-New York City $100
- ☐ NY-New York Western $50
- ☐ OH-Cincinnati $80
- ☐ OH-Northeast Ohio $75
- ☐ OH-Northwest Ohio*
- ☐ OH-Ohio Central $100
- ☐ OK-Oklahoma $75
- ☐ OR-Oregon $100
- ☐ PA/NJ-Eastern PA/South NJ $100
- ☐ PA-Central Pennsylvania $40
- ☐ PA-Pittsburgh $25
- ☐ PR-Puerto Rico $50
- ☐ RI-Rhode Island $50
- ☐ SC-South Carolina $50
- ☐ SD-South Dakota
- ☐ TN-Tennessee $20
- ☐ TX-Texas*
- ☐ UT-Intermountain $55
- ☐ VA-Virginia $50
- ☐ VT-Vermont $75
- ☐ WA-Washington State $100
- ☐ WI-Wisconsin $75
- ☐ 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

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.