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

Training Verification Form

This form is to be completed by your Program Director or Coordinator. Your membership cannot be processed until this form has been completed and submitted to AACAP. This form must be completed within 30 days of submitting your membership application in order to be processed.

Applicant's Full Name | Date

Email Address | Telephone Number

The above applicant is applying for membership in the American Academy of Child & Adolescent Psychiatry and must verify medical school enrollment. Please complete this form and return it to the applicant. Thank you for your time and assistance.

Name of Training Institution | Type of Training | Start Date | Anticipated Completion Date

Is the above applicant completing training in a satisfactory manner? ☐ Yes ☐ No

If no, please explain

The above applicant is a ☐ Full-time Resident ☐ Part-time Resident

If part-time, please insert the dates and percent of time for training:

Percent | From (date) | To (date) | Reason

Percent | From (date) | To (date) | Reason

By checking the box and writing my full legal name below, I affirm the information on this application to be true.

☐ I affirm the information on this application is true.

Signature | Date

Email Address | Title/Position

This completed verification form can be submitted by:
1) Email - Send to memberservices@aacap.org
2) Fax or Mail - Fax to 202.464.0131, or mail to:

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

If you have questions regarding your application, please call 202.966.7300 ext. 2004 or email membership@aacap.org.