American Academy of Child & Adolescent Psychiatry
www.aacap.org

Medical School Enrollment Verification Form

This form is to be completed by one of the following: the Dean, the Dean's designee, or Supervisor.
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 Medical School | Type of Training

Start Date | Anticipated Completion Date

E-mail address | Telephone number

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

If no, please explain

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

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

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 application can be submitted to:

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

By email: memberservices@aacap.org

By fax 202.464.0131

PLEASE REMEMBER TO FAX THE FRONT AND BACK OF THE APPLICATION.

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