

## Medical School Enrollment Verification Form

This form is to be completed by one of the following: the Dean, the Dean's designee, or the Director of Medical Student Education in CAP Psychiatry, Psychiatry, or Pediatrics. Your membership cannot be processed until this form is completed.

|                       |                  |
|-----------------------|------------------|
| 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 |
|---------|-------------|-----------|--------|
|         |             |           |        |
|         |             |           |        |

If there were interruptions in training, please indicate the dates and reason:

| 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 - Select "Submit by Email" button at the top of this page.
- 2) Fax or Mail - Select "Print" button at the top of the page and 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 or by fax 202.464.0131.