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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
Percent	From (date)	To (date)	Reason

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

From (date)	To (date)	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.