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PROFESSIONAL ACTIVITY VERIFICATION FORM

This form must be completed by an AACAP member who is familiar with your present professional work in child and adolescent psychiatry.

Applicant's Full Name	Date

Applying for:

☐ General Membership ☐ Affiliate Membership ☐ Corresponding Membership

The above named person is applying for membership in the American Academy of Child & Adolescent Psychiatry. The applicant needs to verify his/her professional activities. Please review the excerpt below from the AACAP Bylaws regarding membership requirements.

(excerpt taken from Article III Membership, Section 3a)

(a). Election to General Membership in the corporation may be extended, upon application, to any licensed physician who meets both of the following qualifications:
1). Shall have been certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology, or have completed two years of training in a child and adolescent psychiatry training program accredited by the Accreditation Council on Graduate Medical Education, and have completed general psychiatry training.
2). Shall demonstrate, through documentation, that his/her major professional interest and activity is in child and adolescent psychiatry. Activities may be in one or more of the following areas: clinical practice, teaching, research, administration, scholarly publication, or organizational or social policy work at community, state, or national levels.

(excerpt taken from Article III Membership, Section 5a)

(a). Affiliate Membership in the corporation may be extended, upon application, to any physician who is not eligible for General Membership but who is making contributions to the field of child and adolescent psychiatry in one or more of the activities listed in Section 3, (a), (2) of this Article III.

(excerpt taken from Article III Membership, Section 7a)

(a). Election to Corresponding Membership may, upon application, be extended to any physician living outside the United States who would otherwise qualify for election to membership in any of the previously described membership classes.

Please answer the following questions.

1). Are you familiar with the applicant's professional work? ☐ Yes ☐ No
2). If yes, does the applicant meet the membership requirements of the AACAP? ☐ Yes ☐ No
3). If no, please explain how you feel the applicant meets the membership requirements of the AACAP outside of their professional activities:

Past association | Reputation in your community | Other (please specify)

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 by email to membership@aacap.org, fax to 202.464.0131 or by 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.

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