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TRAINING VERIFICATION FORM

This form is to be completed by your Program Director. Your membership cannot be processed until this form has been completed and submitted to AACAP.

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

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
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