

MEDICAL STUDENT APPLICATION

Medical Student membership is free to full-time students enrolled in an accredited medical school. In order to process your application, you must complete all of the information below and have the enrollment verification on the opposite side of this form completed by the appropriate administrative staff or Dean.

Also available online at www.aacap.org.

Last Name	First Name	Middle	Today's date
Street Address			
City	State/Province	Zip/Postal Code	
Country (if not U.S.)	Telephone number	Fax number	
E-mail address			Date of birth

I am interested in:

General Psychiatry Pediatrics Child and Adolescent Psychiatry

Dual membership in a child and adolescent regional organization is required per the Bylaws and is free for medical students. Regional organizations are assigned based on the locality of your institution during the processing of your application.

Medical School Information

School Name	Name of Dean	
School Street Address	City, State, Zip	Country
Start Date	Anticipated Completion Date	

Have you ever been found at fault by any medical board or professional ethics review committee, or are you now under investigation by any such group?

Yes (if yes, please submit an explanation) No

I understand that my application will be reviewed by the Membership Credentials Committee and my regional organization. I understand that the organization may make inquiries about my professional training if deemed necessary. I understand that the organization is not obligated to offer membership on the basis of this application.

I have read the AACAP Bylaws and the Code of Ethics and agree to abide by them. If accepted, I pledge to abide by the regulations of the AACAP as well as to high standards of ethical practice.

I affirm that the information on this application is true.

Signature _____

Date _____

Demographic Information

This information is necessary for some AACAP federal grants.

Gender (Male / Female)	Ethnicity (Hispanic or Latino / Non-Hispanic or Latino)	List language(s)
Race (American Indian or Alaska Native / Asian / African American or Black / Caucasian or White / Native Hawaiian or Other Pacific Islander / Other)		

Are you a member of the American Medical Association: Yes No

Are you a member of the American Psychiatric Association: Yes No

Are you a member of the American Academy of Pediatrics: Yes No

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Enrollment Verification Form

This form is to be completed by your program director or by the Dean. 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

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

Print Name

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 or 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.