

RESIDENT APPLICATION

Resident membership is \$100 and includes an annual subscription to the *Journal of the American Academy of Child and Adolescent Psychiatry*. In order to process your application, you must complete all of the information below and submit the appropriate training verification forms. 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	

Please indicate the resident membership category you are applying for:

- Child and Adolescent Psychiatry Resident (submit verification of enrollment in child and adolescent psychiatry training program)
- General Psychiatry Resident (submit verification of enrollment in general psychiatry training program)
- Pediatric Resident (submit verification of enrollment in pediatric training program)
- I am a triple board resident. (submit verification of enrollment in current psychiatry training program)

Education Program Information

Child and Adolescent Psychiatry and triple board residents must complete all sections below. If you are applying as a General or Pediatric resident, please complete the first two sections.

Medical School Information

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

Residency Information

Program Name	Program Type (General Psychiatry/Pediatrics/Other)		
Name of Program Director	Start Date	Anticipated Completion Date	
School Street Address	City, State, Zip		Country

CAP Residency Information

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

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

RESIDENT APPLICATION

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 Committee and my regional organization. I understand that the organization may make inquiries about my professional training and practices 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 _____

Regional Organization Membership - General Members Only

Dual membership in a regional organization is required per the Bylaws and any associated dues should be included with your enclosed payment for annual membership fees. Assignment to a regional organization should be based on the locality of practice. Please select a regional child and adolescent psychiatry organization.

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> AK-Alaska | <input type="checkbox"/> FL-North Central Florida \$10 | <input type="checkbox"/> ME-Maine | <input type="checkbox"/> NY-New York Capital | <input type="checkbox"/> PR-Puerto Rico \$20 |
| <input type="checkbox"/> AL-Alabama \$10 | <input type="checkbox"/> FL-South Florida \$20 | <input type="checkbox"/> MI-Michigan \$40 | <input type="checkbox"/> NY-New York City | <input type="checkbox"/> RI-Rhode Island |
| <input type="checkbox"/> AR-Arkansas | <input type="checkbox"/> FL-Tampa Bay | <input type="checkbox"/> MN-Minnesota \$50 | <input type="checkbox"/> NY-New York Western* | <input type="checkbox"/> SC-South Carolina \$15 |
| <input type="checkbox"/> AZ-Arizona | <input type="checkbox"/> GA-Georgia | <input type="checkbox"/> MO-St. Louis | <input type="checkbox"/> OH-Cincinnati \$10 | <input type="checkbox"/> SD-South Dakota |
| <input type="checkbox"/> CA-Central California | <input type="checkbox"/> HI-Hawaii \$25 | <input type="checkbox"/> MS-Mississippi | <input type="checkbox"/> OH-Northeast Ohio \$20 | <input type="checkbox"/> TN-Tennessee |
| <input type="checkbox"/> CA-Northern California \$50 | <input type="checkbox"/> IL-Illinois \$40 | <input type="checkbox"/> MT-Montana Big Sky* | <input type="checkbox"/> OH-Northwest Ohio* | <input type="checkbox"/> TX-Texas* |
| <input type="checkbox"/> CA-San Diego \$20 | <input type="checkbox"/> IN-Indiana \$5 | <input type="checkbox"/> NE-Nebraska | <input type="checkbox"/> OH-Ohio Central \$100 | <input type="checkbox"/> UT-Intermountain \$23 |
| <input type="checkbox"/> CA-Southern California | <input type="checkbox"/> KS-Kansas \$10 | <input type="checkbox"/> NC-North Carolina | <input type="checkbox"/> OK-Oklahoma \$20 | <input type="checkbox"/> VA-Virginia |
| <input type="checkbox"/> CO-Colorado \$30 | <input type="checkbox"/> KY-Kentucky | <input type="checkbox"/> ND-North Dakota | <input type="checkbox"/> OR-Oregon | <input type="checkbox"/> VT-Vermont |
| <input type="checkbox"/> CT-Connecticut | <input type="checkbox"/> LA-Louisiana | <input type="checkbox"/> NJ-New Jersey | <input type="checkbox"/> PA/NJ-Eastern PA/South NJ | <input type="checkbox"/> WA-Washington State |
| <input type="checkbox"/> DC-Greater Washington \$25 | <input type="checkbox"/> MA-New England* | <input type="checkbox"/> NM-New Mexico | <input type="checkbox"/> PA-Central Pennsylvania | <input type="checkbox"/> WI-Wisconsin |
| <input type="checkbox"/> DE-Delaware \$15 | <input type="checkbox"/> MD-Maryland | <input type="checkbox"/> NV-Nevada | <input type="checkbox"/> PA-Pittsburgh | <input type="checkbox"/> WY-Wyoming |

Note: *Regional organizations denoted with an asterisk identify separate dues billing process. You will receive an invoice directly from the regional organization for your regional membership dues. Regional organization dues are subject to change.

Payment Information

Payment must be submitted by check, money order or credit card. Checks must be drawn from a U.S. bank. Send your completed application materials and dues payment to:

American Academy of Child & Adolescent Psychiatry, Attn: Member Services
3615 Wisconsin Ave, N.W.
Washington, DC 20016

Applications submitted after June 30 are only required to pay half of the annual membership fee for the current year.

Credit Card Payment (Please note, we do not accept credit cards other than those below).

AMEX MC VISA

_____ _____ _____
Total enclosed CC # Exp. date

_____ _____
Authorizing signature of cardholder Date

You can fax your completed application with credit card payment to 202.464.0131. **PLEASE FAX THE FRONT AND BACK OF THE APPLICATION AND ANY RELEVANT VERIFICATION FORMS.** Once your application has been received, please allow 3-5 business days for processing. An electronic receipt will be sent to the e-mail address listed on the front of this application. If approved, you will receive notification by e-mail and a new member orientation packet will be mailed.

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