



# Application For Membership

(Type or print all information)

District of Columbia Chapter

**Name** \_\_\_\_\_  MD  DO  Other \_\_\_\_\_  
 (First) (Middle/maiden) (Last)

**Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Birth date** \_\_\_\_\_  Male  Female

**Mailing Address**  Home  Office

\_\_\_\_\_  
 (Street)

\_\_\_\_\_  
 (Street)

\_\_\_\_\_  
 (City) (State) (Zip code)

**Phone 1** \_\_\_\_\_  Work  Home  Cell

**Phone 2** \_\_\_\_\_  Work  Home  Cell

**Phone 3** \_\_\_\_\_  Work  Home  Cell

**Fax** \_\_\_\_\_

**E-Mail Address** \_\_\_\_\_

**Are you currently a member of the AAP (National)?**  No  Yes - Membership # \_\_\_\_\_

**Are you currently a member of another state chapter? If yes, where -** \_\_\_\_\_

## MEDICAL EDUCATION

<i>Institution</i>	<i>Location</i>	<i>From (Mo/Yr)</i>	<i>To (Mo/Yr)</i>
_____	_____	_____	_____
_____	_____	_____	_____

## RESIDENCY TRAINING

<i>Type</i>	<i>Institution</i>	<i>Location</i>	<i>From (Mo/Yr)</i>	<i>To (Mo/Yr)</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## FELLOWSHIP TRAINING

<i>Type</i>	<i>Institution</i>	<i>Location</i>	<i>From (Mo/Yr)</i>	<i>To (Mo/Yr)</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If there is a break in chronology before, during, or after residency training, please describe on a separate page.

## BOARD CERTIFICATION\*

**Are you certified by the American Board of Pediatrics?**  No  Yes – Date \_\_\_\_\_

Subspecialty Board \_\_\_\_\_ Certification Date \_\_\_\_\_

Subspecialty Board \_\_\_\_\_ Certification Date \_\_\_\_\_

\*Applicants certified by a board other than the American Board of Pediatrics must include a photocopy of the certificate of board certification.

**MEDICAL CAREER ACTIVITIES** In the space below, detail your professional activities after training through the present.

Type of Professional Activity	Location	Date Started	Date Completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If currently in the armed forces: Branch \_\_\_\_\_ Rank \_\_\_\_\_

**MEDICAL LICENSE** Where licensed? \_\_\_\_\_

Has your medical license ever been revoked, suspended, or restricted?  Yes  No  
*If yes, please detail on a separate page.*

Are you aware of any current inquiry, investigation, complaint, or other proceeding that could result in the revocation, suspension, or restriction of your medical license?  Yes  No  
*If yes, please detail on a separate page.*

**HOSPITAL STAFF POSITION**

Institution \_\_\_\_\_ Location \_\_\_\_\_  
 Active \_\_\_\_\_ Courtesy \_\_\_\_\_  
 How long? \_\_\_\_\_

**SIGNATURE**

I hereby certify that all information recorded on this application and any attached documents is accurate and supports my qualifications for membership in the DC Chapter, AAP for which I now apply.

\_\_\_\_\_  
 (Personal signature of applicant) (Date)

*If the DC Chapter, AAP learns that any information in your application is untrue, or if circumstances change after the date of application that effect ethical and professional standards, it may be grounds for suspension or revocation of membership.*

*Membership in the DC Chapter of the American Academy of Pediatrics is automatically renewed each July 1<sup>st</sup>. Cancellation of membership must be submitted in writing and cannot be granted retroactively.*

**Annual dues: \$65.00**

Please submit application and check made payable to **DC American Academy of Pediatrics** to:

President, DC AAP  
 PO Box 26383  
 Washington, DC 20001

A receipt will be mailed to the address you provided to keep for your records.