

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Pennsylvania Chapter

Application

Chapter Membership Application (Type or print all information)

1. **Name** _____ MD DO Other (Specify) _____
(first) (middle/maiden) (last)

Social Security Number _____

2. **Mailing Address** Home
 Office _____
(street)

_____ (city) (state/province) (zip code plus 4)

Telephone _____ Home Office **Office Fax #** _____

3. **Birthdate** _____ Male Female **E-Mail Address** _____

Education and training

Please note the dates and locations of all educational training below.

4. MEDICAL EDUCATION:

Institution	Location	From MO/YR	To MO/YR
_____	_____	_____	_____
_____	_____	_____	_____

5. RESIDENCY TRAINING:

Type	Institution	Location	From MO/YR	To MO/YR
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5a. FELLOWSHIP TRAINING:

Type	Institution	Location	From MO/YR	To MO/YR
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

6. **BOARD CERTIFICATION*:** Yes No
 Specialty 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.

7. **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 _____

8. **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 Has your medical license ever been revoked, suspended, or restricted?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.

9. **HOSPITAL STAFF POSITION**

Institution _____ Active _____ Courtesy _____
 Location _____ How long? _____

10. **CURRENT MEDICAL SCHOOL APPOINTMENT**

11. **SPONSOR:** (Must be AAP Fellows or Specialty Fellows in good standing)

Name _____ Address _____
 Name _____ Address _____

*Some sections require Specialty Fellow applicants to provide sponsor statements from section members and/or Fellows residing in the same community as the applicant. Details on sponsor requirements are provided on the individual section criteria sheet.

12. **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 PA Chapter, AAP for which I now apply.

 (Personal signature of applicant)

 Date

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

Membership in the PA Chapter of the American Academy of Pediatrics is automatically renewed each July 1st. Cancellation of membership must be submitted in writing and cannot be granted retroactively.

2011 - 2012 Annual dues:

Fellow/Specialty Fellow	\$175	Retired Fellow	\$175
Candidate Member	\$115	Associate Member	\$175
Post Resident Training Member	\$ 85	Resident	Free
Emeritus Fellow	Free	Medical Student	Free