AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

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

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

Percent From (date) To (date) Reason

If there were interruptions in training, please 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

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.