

CHAPTER AFFILIATE APPLICATION

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

FOR AAP USE ONLY

AAP ID# _____

DIST _____ CHAPTER _____

Members who choose to belong only to their state Chapter and not national (AAP) are called "Chapter Affiliates".

First Name _____ Middle/Maiden _____ Last Name _____
 MD DO DDS PA CNP Other (specify) _____ Male Female _____
Date of Birth (MM/DD/YYYY) ____/____/____

Preferred Address & Phone Home –or– Office

Organization Name (if applicable) _____

Number/Street/Suite _____

City/State/Zip or Postal Code/Country _____

Telephone _____ Cellular _____

Email _____ Fax _____

I AM APPLYING FOR CHAPTER AFFILIATE MEMBERSHIP IN NEW MEXICO

FELLOWSHIP TRAINING (if applicable)

Type of Fellowship _____ Institution _____
From (MM/DD/YY) ____/____/____ To (MM/DD/YY) ____/____/____

BOARD/PROFESSIONAL CERTIFICATION (if applicable)

Board or Sub-Board _____ Certificate Date _____

MILITARY SERVICE (if applicable)

If you are or were in the Uniformed Service, please indicate which branch: Army Navy Air Force Public Health Service
What is/was your rank? _____ Are you in the reserves? Yes No ••• Are you retired? Yes No

APPLICANT SIGNATURE

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

Signature of Applicant _____ Date _____

PAYMENT OPTIONS

To pay your Chapter dues payment please complete below.

My check for \$ _____ is enclosed – Check # _____
 I will pay using the following credit card: Visa Mastercard AMEX Discover Include the 3-digit CVV# located on the signature space of your card.

Amount \$ _____ • Cardholder Name _____

Card # _____ • CVV# _____ • Exp. Date ____/____

Signature _____ Date _____

DUES: MD/DO/DDS \$140.00; CNP/PA/Other \$75.00

Mail to: American Academy of Pediatrics, Division of Member Relations, 141 Northwest Point Blvd., Elk Grove Village, IL 60007