

GEORGIA CHAPTER
American Academy of Pediatrics
CHAPTER MEMBERSHIP APPLICATION

Please notify the office when your contact information changes! Thanks.

First Name _____ Last Name _____

Designation: MD DO DDS/DMD PNP RN Other _____

Mailing Address (Office) _____

City _____ State _____ Zip code _____ - _____ County _____

Mailing Address (Home) _____

City _____ State _____ Zip code _____ - _____ County _____

Phone _____ Is this home or work?

Fax _____ Email _____

Practice/Hospital/Institution Name *(If Applicable)* _____

Office Manager/Assistant _____

Date of Birth _____ Male Female AAP ID _____

Please indicate your training: A) Primary Care Pediatrics

B) Pediatric Subspecialty *(Please indicate below)*

C) Other _____

- Adolescent Medicine
- Allergy & Immunology
- Anesthesiology
- Cardiology
- Child Abuse
- Critical Care
- Dentistry (Pediatric)
- Dermatology
- Developmental/Behavioral Pediatrics
- Emergency Medicine
- Endocrinology
- Gastroenterology
- Genetics
- Hematology/Oncology
- Hospice & Palliative Medicine
- Infectious Diseases
- Med/Peds
- Medical Toxicology
- Neonatal/Perinatal Pediatrics

- Nephrology
- Neurodevelopmental Disabilities
- Neurology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Plastic Surgery
- Psychiatry
- Pulmonology
- Radiology
- Rehabilitation Medicine
- Rheumatology
- Sleep Medicine
- Sports Medicine
- Surgery
- Transplant Hepatology
- Urology
- Other _____

Please indicate your *PRIMARY* type of practice or employment:

- A) Academic
- B) Hospital based (*Includes administration and/or patient care*)
- C) Managed Care (*Includes administration and/or patient care*)
- D) Military
- E) Private Practice (*Solo*)
- F) Private Practice (*Group – 2 or more*)
- G) Public Health (*State or Local*)
- H) Public Health (*Federal*)
- I) Other (*please specify*) _____

Categories of Chapter Membership:

	DUES	CODE
<input type="checkbox"/> Fellow (<i>Fellow, American Academy of Pediatrics</i>)	\$205	(00)
<input type="checkbox"/> Specialty Fellow (<i>Specialty other than Pediatrics</i>)	\$205	(02)
<input type="checkbox"/> Resident Fellow (<i>Resident program in Georgia</i>)	\$0	(03)
<input type="checkbox"/> Chapter Affiliate (<i>Chapter member, but non-member of AAP</i>)	\$205	(20)
<input type="checkbox"/> Candidate Fellow (<i>Maximum 7 years – post residency</i>)	\$150	(30)
<input type="checkbox"/> Post Residency Training Fellow	\$80	(40)
<input type="checkbox"/> Senior Members (<i>65 years of age or older & retired from active practice</i>)	\$0	(05)
<input type="checkbox"/> Associate Member (<i>Pediatric Dentist</i>)	\$105	(79)
<input type="checkbox"/> Associate Affiliate (<i>Nurses, NPs, PAs, etc.</i>)	\$105	(89)
<input type="checkbox"/> Medical Students (<i>Medical school in GA</i>)	\$0	(88)

Payment Enclosed Please send me an invoice for Chapter Dues

Please charge my Credit Card Choose one: MasterCard Visa American Express

Card Number _____ Exp. _____

Name on Card _____ CVV code: _____

Signature _____

Are you interested in serving on a chapter committee? Yes No

If yes, please list any committees in which you are interested _____

Please list areas of professional interest and additional expertise _____

Please return to:

Georgia Chapter/ American Academy of Pediatrics Attn: Membership
1350 Spring Street, Suite 700, Atlanta, GA 30309
Phone: 404/881-5067 Fax: 404/249-9503 asmith-adams@gaaap.org