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 turn application over & continue* →

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
☐ Fellow *(Fellow, American Academy of Pediatrics)*	$205	*(00)*
☐ Specialty Fellow *(Specialty other than Pediatrics)*	$205	*(02)*
☐ Resident Fellow *(In a resident program in Georgia)*	$0	*(03)*
☐ Chapter Affiliate *(Chapter member, but non-member of National AAP)*	$205	*(20)*
☐ Candidate Fellow *(Maximum 7 years – post residency)*	$160	*(30)*
☐ Post Residency Training Fellow	$90	*(40)*
☐ Senior Members *(65 years of age or older & retired from active practice)*	$0	*(05)*
☐ Associate Member *(Pediatric Dentist and Psy.D)*	$115	*(79)*
☐ Associate Affiliate *(Nurses, NPs, PAs, etc.)*	$115	*(89)*
☐ Medical Students *(A medical school in Georgia)*	$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

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