



Join APA Online! Complete your membership application online and submit it electronically to the APA Membership Department at www.psych.org JOIN APA.

My application is being submitted in response to your Member-Get-A-Member campaign. I am being referred by:

Member Name: _____ Member ID Number: _____

I am a physician who has completed acceptable psychiatry training (as approved by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons (Canada) or the American Osteopathic Association) and I have a valid license to practice medicine or I have an academic, research or governmental position that does not require licensure.

I am applying for membership in the APA through the following District Branch/State Association: _____
(Please see the APA District Branch/State Association list on the back cover of this brochure)

Are you a former member of APA? Yes No If YES, please provide your former name: _____

DUES AMNESTY FOR FORMER MEMBERS OWING PAST DUES: Former members who owe past dues may be eligible for a one time "dues amnesty" for past district branch and APA dues. To be eligible, your district branch must participate in the program and waive past district branch dues. Visit www.psych.org/membership for details.

BIOGRAPHICAL INFORMATION

LAST NAME FIRST NAME MI SUFFIX

PREFERRED MAILING ADDRESS (LINE 1) [] HOME [] OFFICE (REQUIRED)

PREFERRED MAILING ADDRESS (LINE 2) DEGREE (M.D., Ph.D., MPH)

CITY, STATE/PROVINCE, ZIP/POSTAL CODE

AREA CODE AND HOME TELEPHONE AREA CODE AND OFFICE TELEPHONE AREA CODE AND FAX NUMBER [] HOME [] OFFICE

E-MAIL ADDRESS [] HOME [] OFFICE
M M D D Y Y

DATE OF BIRTH COUNTRY OF BIRTH LANGUAGES SPOKEN (OTHER THAN ENGLISH)

OPTIONAL SECONDARY ADDRESS (LINE 1) [] HOME [] OFFICE

CITY, STATE/PROVINCE, ZIP/POSTAL CODE

DEMOGRAPHIC DATA

The following categories are for statistical purposes only. This information will not be considered in connection with your application for membership.

Gender: Male Female

Ethnicity/Race: (Check all that are applicable.)

Are you Spanish/Hispanic/Latino?

- No, not Spanish/Hispanic/Latino
- Yes, Mexican, Mexican-American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Other Spanish/Hispanic/Latino

- American Indian or Alaska Native
- Asian: Indian & Indian Subcontinent
- Asian: Chinese
- Asian: Filipino
- Asian: Japanese
- Asian: Korean
- Asian: Vietnamese
- Asian: Other
- Black: Afro-American
- Black: Afro-Caribbean
- Black: African
- Black: Other
- Middle Eastern
- Pacific Islander: Native Hawaiian
- Pacific Islander: Guamanian or Charmorro
- Pacific Islander: Samoan
- Pacific Islander: Other
- White
- Other, Specify: _____
- Unreported

ETHICS

Has your license to practice medicine ever been revoked or suspended?

Yes No

Are you currently charged with illegal or unethical professional conduct by a regulatory or law enforcement agency or by a professional society?

Yes No

Have you ever been found guilty of illegal or unethical professional conduct by a regulatory or law enforcement agency or by a professional society?

Yes No

If you answered YES to any of the three preceding questions, please provide details in a confidential communication to the APA Membership Committee Chair and attach the details to this application.

ACADEMIC TRAINING

MEDICAL SCHOOL

SCHOOL

CITY/STATE OR COUNTRY

STARTED (MONTH/YEAR)

FINISHED (MONTH/YEAR)

DEGREE

PSYCHIATRY RESIDENCY TRAINING (and other medical specialty training, including fellowship programs; list most recent first.)

Certificate of completion is attached. Yes No

TRAINING PROGRAM/SCHOOL

CITY/STATE OR COUNTRY

STARTED (MONTH/YEAR)

FINISHED (MONTH/YEAR)

SPECIALTY

TRAINING PROGRAM/SCHOOL

CITY/STATE OR COUNTRY

STARTED (MONTH/YEAR)

FINISHED (MONTH/YEAR)

SPECIALTY

TRAINING: Does the preceding training information reflect recognized completion of residency training in psychiatry approved by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association?

Yes No If YES, how many full years of psychiatric residency training have you completed? _____

WORK SETTINGS: (Paid and unpaid). Rank answers 1, 2, or 3, by time spent.

- | | |
|--|---|
| <input type="checkbox"/> Community Mental Health Center | <input type="checkbox"/> Inpatient Unit-Public Psych Hospital, including Partial Hospital |
| <input type="checkbox"/> Correctional or Forensic Facility | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Federal/Military Setting | <input type="checkbox"/> Outpatient Clinic-Private or Freestand |
| <input type="checkbox"/> Federal/Veteran's Administration | <input type="checkbox"/> Outpatient Clinic-Public Hospital or Freestand |
| <input type="checkbox"/> Group Office Practice, Traditional | <input type="checkbox"/> Residential Treatment Center |
| <input type="checkbox"/> Inpatient Unit-Private General Hospital, including Partial Hospital | <input type="checkbox"/> Solo Office Practice |
| <input type="checkbox"/> Inpatient Unit-Private Psych Hospital, including Partial Hospital | <input type="checkbox"/> Group Model HMO Clinic |
| <input type="checkbox"/> Inpatient Unit-Public General Hospital, including Partial Hospital | <input type="checkbox"/> Student/College Mental Health |
| | <input type="checkbox"/> Other, Specify _____ |

BOARD CERTIFICATION: Please list any board certifications (i.e. ABFP, ABPN, AOA, RCPS(C), other). List area(s) that you are certified in and include the start date and end date (MM/DD/YYYY) of the certification.

DOCUMENTATION: To expedite the application process, please complete the section below and attach a copy of your medical license.

STATE AND LICENSE NUMBER (REQUIRED)

EXPIRATION DATE (IF APPLICABLE)

To avoid unnecessary delay, be sure to submit appropriate documentation.

License enclosed. A copy of my current, valid medical license is enclosed with my membership application.

Residency Training Completion Certificate enclosed. My residency training completion certificate is enclosed with my membership application.

Not required. I am a physician in an academic, research or governmental position not requiring a license.

AGREEMENT

I agree to abide by the bylaws of APA and its District Branches and State Associations. I understand that the organization will make inquiries about me and that I am not entitled to, and will not ask for, a disclosure of these replies. I will hold APA and its District Branches/State Associations, members, officers, employees, and agents free from all damage and complaint by reason of action taken on this application or by reason of any subsequent action on membership, including the sharing between the APA Office of Membership and District Branches/State Associations of information about my professional conduct. I pledge myself to standards of ethical practice and conduct as specified in the bylaws of APA and in the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. I certify that the above information is accurate, and I understand that inaccurate information can invalidate my application. My signature means that I agree to the conditions above and on the reverse of this application.

SIGNATURE

DATE

MEMBER PROFILE UPDATE

As a member of the American Psychiatric Association (APA), your professional information is secured on the Member Profile Update page. You can update your contact, biographical and practice data information any time by accessing your membership record in Member's Corner at www.psych.org. Periodically checking and updating your membership record will make it easier for other members to get in touch with you (and you with them)—now patient referrals can be dependably made using the most current and up-to-date information possible! **Another great benefit from the APA.**

APA GENERAL MEMBER • MEMBERSHIP APPLICATION

The American Psychiatric Association/District Branch/State Association membership year runs from January 1 through December 31. Members enrolled in April or after are invoiced a prorated amount for APA/District Branch membership dues. Membership is continuous on an annual basis, unless written notification is received from the member or the membership is terminated for nonpayment of membership dues or failure to meet the APA—District Branch/State Association joint membership requirement. **District Branch/State Association dues are fixed by each individual branch.** Enrollment is effective the first month following approval of your application by the APA Membership Department and your District Branch/State Association. Membership in APA and the District Branch/State Association is simultaneous; you must be a member of both to be a member of either.

To ensure prompt processing of your membership application, be sure to:

- Sign and date the membership application.
- Do NOT send payment for membership dues with this application. You will be billed following enrollment.

Please complete and return this application to:

American Psychiatric Association
Membership Department MS#5 1808
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901

www.psych.org
Email: apa@psych.org
Fax: 703-907-1085

QUESTIONS? Call 1-888-35-PSYCH or 703-907-7300

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