



**Join APA Online!** Complete your membership application online and submit it electronically to the APA Membership Department at [www.psych.org](http://www.psych.org) JOIN APA.

- 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](http://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.

\_\_\_ Community Mental Health Center

\_\_\_ Correctional or Forensic Facility

\_\_\_ Federal/Military Setting

\_\_\_ Federal/Veteran's Administration

\_\_\_ Group Office Practice, Traditional

\_\_\_ Inpatient Unit-Private General Hospital, including Partial Hospital

\_\_\_ Inpatient Unit-Private Psych Hospital, including Partial Hospital

\_\_\_ Inpatient Unit-Public General Hospital, including Partial Hospital

\_\_\_ Inpatient Unit-Public Psych Hospital, including Partial Hospital

\_\_\_ Nursing Home

\_\_\_ Outpatient Clinic-Private or Freestand

\_\_\_ Outpatient Clinic-Public Hospital or Freestand

\_\_\_ Residential Treatment Center

\_\_\_ Solo Office Practice

\_\_\_ Group Model HMO Clinic

\_\_\_ Student/College Mental Health

\_\_\_ 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

In consideration of my membership in the APA, the District Branch and/or the State Association, which I understand is a privilege and not a right, I agree that APA may make inquiries about me and that I am not entitled to the results, that I will pay the dues required on or before the due date, that I will adhere to the standards of ethical practice and conduct as well as the procedures outlined in the *Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, that APA may publish my membership data in its membership database to which all members and third parties permitted by APA will have access, that APA may provide government authorities all information pertaining to me if in receipt of a subpoena from authorities or if the institution seeking the information is a public institution which has paid all or any portion of my membership dues or CME fees, and that I will hold APA, the District Branch and the State Association harmless from any and all liability arising out of or relating to my membership, including but not limited to, decisions concerning membership, ethics, and/or the provision or storage of my personal and/or financial information. Any disputes that arise out of or relate to this agreement and/or my membership shall be governed by Virginia law without regard to its choice of law principles and any hearings or proceedings shall be heard in the state of Virginia.

SIGNATURE

DATE

## 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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