Medical Student Membership Application

Join Today.

Detach and fax or return this application to:

American Psychiatric Association
Membership Department MS#5 1808
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209-3901
Phone: 703.907.7300
Toll Free: 888.35.PSYCH, 888.357.7924
Fax: 703.907.1085
apa@psych.org
www.psych.org

BIOGRAPHICAL INFORMATION

❑MALE ❑FEMALE

LAST NAME • FIRST NAME • MI • SUFFIX

MAILING ADDRESS (LINE 1)

MAILING ADDRESS (LINE 2)

CITY | PROVINCE/STATE | COUNTRY | ZIP/POSTAL CODE

TELEPHONE (WITH AREA CODE) | EMAIL ADDRESS

MEDICAL SCHOOL • BIRTH DATE (M M D D Y Y)

CITY | PROVINCE/STATE | COUNTRY | ZIP/POSTAL CODE

DATE ENTERED MEDICAL SCHOOL (MO/YR) (M M Y Y) | EXPECTED DATE OF GRADUATION (MO/YR) (M M Y Y)

ENDORSEMENT

I recommend the above applicant for membership and certify the applicant's training as indicated above.

CHAIR, DEPARTMENT OF PSYCHIATRY/FACULTY (PLEASE PRINT NAME)

SIGNATURE (APA MEMBER NUMBER)

MEDICAL SCHOOL

Please accept my application for Medical Student membership in the American Psychiatric Association. I understand that I am eligible for APA Medical Student membership as long as I am enrolled in an accredited U.S. or Canadian medical school. If, upon graduation, I have chosen to enter an approved psychiatric residency training program, I will then be eligible to apply for membership as an APA Member-in-Training. My signature indicates that I agree to abide by the Bylaws of the APA; I will hold APA members, officers, employees, and agents free from all damage and complaint by reason of any action taken on this application, or by reason of any subsequent action on membership; and I pledge myself to the highest standards of ethical practice and conduct.

SIGNATURE | DATE

EMAIL ADDRESS

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