



**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 in a psychiatric residency training program 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.

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: \_\_\_\_\_

Does your residency training program pay for your APA membership dues?  Yes  No

**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 OR EXPECTED (MONTH/YEAR) \_\_\_\_\_ DEGREE \_\_\_\_\_

**Psychiatry Residency Training** (and other medical specialty training, including fellowship programs; list the most recent training first and include copies of training certificates).

TRAINING PROGRAM/SCHOOL \_\_\_\_\_

CITY/STATE OR COUNTRY \_\_\_\_\_

STARTED (MONTH/YEAR) \_\_\_\_\_ FINISHED OR EXPECTED (MONTH/YEAR) \_\_\_\_\_ SPECIALTY \_\_\_\_\_

TRAINING PROGRAM/SCHOOL \_\_\_\_\_

CITY/STATE OR COUNTRY \_\_\_\_\_

STARTED (MONTH/YEAR) \_\_\_\_\_ FINISHED OR EXPECTED (MONTH/YEAR) \_\_\_\_\_ SPECIALTY \_\_\_\_\_

**Psychiatric Residency Endorsement** — Members-In-Training must have the following endorsement signed by his/her training director:

**Endorsement:** I recommend the above applicant for membership in the American Psychiatric Association and certify the applicant's psychiatric training as listed above.

SIGNATURE (DIRECTOR OF TRAINING) \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF TRAINING PROGRAM/INSTITUTION \_\_\_\_\_

## 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 \_\_\_\_\_

Upon completion of psychiatric residency your membership status in the American Psychiatric Association (APA) and District Branch will be advanced to that of general member. In order to facilitate this transition please complete the following authorization allowing your training director to verify that you have successfully completed your residency. Please feel free to call the American Psychiatric Association at 888-357-7924 with any questions you may have.

I, \_\_\_\_\_ give permission to \_\_\_\_\_ (Training Program) to release information about my psychiatric training, including my completion date, to American Psychiatric Association for the sole purpose of maintaining and updating my member file. I understand that this information will also be shared with my District Branch.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## APA MEMBER-IN-TRAINING • MEMBERSHIP APPLICATION

**The American Psychiatric Association/District Branch/State Association membership year runs from January 1 through December 31.** Members enrolled in or after April 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 non-payment 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.** APA national dues are waived for the first year for new resident members. Many District Branches and State Associations also waive local dues for the first year.

*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.*

### Automatic Advancement Process:

Through the Automatic Advancement Process, the APA will automatically advance the MIT to General Member status when training is completed (based on information originally provided by the MIT when joining). All MITs automatically advanced will be billed for the first year of General Member dues effective January 1 as part of the annual membership renewal process. APA staff will notify the advancing MIT to verify they meet the requirements of General Membership. For MITs who do not verify with the APA that they meet General Member requirements, the APA will contact the residency training programs to verify residency completion. APA staff will also attempt to verify licensure information from state license board websites or other sources. If the member is in an academic, research, or government position, a license is not required to complete your advancement. If the member is either continuing advanced training or has not passed the U.S. License Medical Examination (USLME), he/she may continue as an MIT for a specified time period. Please contact APA for further information.

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

- Complete the ethics section of the application.
- Sign and date the membership application.
- Obtain the endorsement signature from your residency training director.
- 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