



**ONLINE**  
**Specialty  
Fellow  
Application**

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™



**A**s a Specialty Fellow of the American Academy of Pediatrics, you'll not only make a valuable investment in your future, but the future of all children. It's only through membership that you'll gain access to a wealth of information designed to enhance your skills and keep you up-to-date on the latest advances in pediatrics.

# Membership Application

## Specialty Fellow

### Qualifications

**S**pecialty Fellow membership applicants must be certified by a Board other than a pediatric board (i.e. The American Board of Pediatrics or the American Osteopathic Board of Pediatrics). Specialty Fellows must meet the requirements as determined by the Section/Council through which they are applying. Specific criteria sheets can be viewed at [www.aap.org/member/secriteria.htm](http://www.aap.org/member/secriteria.htm).

Please check the requirements for the applicable Section/Council before submitting the application.

*Specialty Fellow applicants will be required to join a designated Specialty Section/Council.*

### Application Process

A 12 month membership will begin when an application has been approved and your payment of \$272 (\$544 less 50% 1st year discount) has been processed.

### Please Note

The Academy may require additional information from an applicant or the applicant's cooperation in obtaining information from third parties. Your prompt response to requests for further information or cooperation will minimize any delays in processing your application.

The Academy requires that its members conform to standards of high ethical and professional standing as evaluated by other AAP voting Fellows. Thus, if the Academy learns that any information in an application is untrue or if circumstances change after the date of application that affect ethical and professional standards, it may be grounds for suspension or revocation of membership.

The Academy may provide access to AAP's membership lists or other personal information about members to third party vendors and other third parties who may have information or services that AAP believes could be helpful to members.

In certain instances, AAP benefits by receiving compensation for providing the information or for the members, participation in the programs offered by the vendors. AAP members who wish to opt out of such information sharing can do so by contacting the AAP at 866/843-2271.



### Mission

The mission of the American Academy of Pediatrics is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To accomplish this mission, the Academy shall support the professional needs of its members.

### Core Values

#### *We believe*

- In the inherent worth of all children, they are our most enduring and vulnerable legacy.
- Children deserve optimal health and the highest quality health care.
- Pediatricians are the best qualified to provide child health care.
- The American Academy of Pediatrics is the organization to advance child health and well-being.

### Vision

Children have optimal health and well-being and are valued by society. Academy members practice the highest quality health care and experience professional satisfaction and personal well-being.

## Membership Benefits

### Membership in an AAP Section/Council allows you to:

- Participate in advocacy at the state and/or federal level for children, pediatricians, pediatric subspecialists, and pediatric surgical specialists
- Contribute to educational programming
- Network with your colleagues to ensure high-quality health care for infants, children, adolescents, and young adults
- Network with other pediatricians who are managing practices and medical plans and exchange ideas and solutions to common practice areas
- Join others in your profession to promote your specialty and inform the medical and lay communities of your expertise in providing the best care of pediatric patients
- Participate in workforce studies
- Share knowledge with colleagues via electronic communications, newsletters, special mailings, and business meetings
- Participate in research activities and projects, including participating in the development of practice guidelines
- Be a voice in pediatrics or a pediatric subspecialty

### Additional Benefits

- Certificate of Fellowship
- Participate in National Elections and hold national office within the Academy
- The right to vote
- Use of the "FAAP" designation
- Listing in the Online Membership Directory and Pediatrician Referral Service
- Serve on National Committees, where you can provide expert advice, recommendations and initiatives in your field
- Reduced registration fee for the National Conference and Exhibition, a multi-day conference featuring plenary seminars, workshops, and a technical exhibit area
- **The Red Book: Report of the Committee on Infectious Diseases** (published every three years)
- Online access to the **Member Center** through the AAP Web site – **AAP BookStore, PedJobs, aappolicy.org**
- Subscriptions to **Pediatrics** and **AAP News** (print & online)
- Discounts on all AAP products and services
- Manuals (limited selection) and brochure samples upon request
- Affinity program including: car rental discounts (Avis and Hertz), Bank of America World Points credit card, Pediatric Insurance Consultants – Life, Disability, Dental, Office Overhead, and Geico auto insurance

### Benefits are subject to change.

For more information, contact:

AAP, Division of Member Services & Relations

141 Northwest Point Boulevard, Elk Grove Village, IL 60007  
800/433-9016 • 847/434-4000 • [membership@aap.org](mailto:membership@aap.org)

# Membership Application •• Specialty Fellow

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*If you have previously been a member of the AAP, please call 800-433-9016.*

I am applying as a Specialty Fellow (indicate specialty) \_\_\_\_\_

## INFORMATION (please print)

### FOR AAP USE ONLY

AAP ID# \_\_\_\_\_

DIST \_\_\_\_\_

First Name \_\_\_\_\_ Middle/Maiden \_\_\_\_\_ Last \_\_\_\_\_

MD  DO  Other (specify) \_\_\_\_\_  Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth (MM/DD/YY)

### Home Address & Phone

Check if this is preferred mailing address

Number/Street/Suite \_\_\_\_\_

City/State \_\_\_\_\_

Zip/Postal Code/Country \_\_\_\_\_

Telephone \_\_\_\_\_  Preferred contact number

Cellular Telephone \_\_\_\_\_  Preferred contact number

Home Email \_\_\_\_\_  Preferred email address

### Office Address & Phone

Check if this is preferred mailing address

Organization Name \_\_\_\_\_

Number/Street/Suite \_\_\_\_\_

City/State \_\_\_\_\_

Zip/Postal Code/Country \_\_\_\_\_  Preferred contact number

Telephone \_\_\_\_\_  Preferred contact number

Business Email \_\_\_\_\_  Preferred email address

Fax \_\_\_\_\_

## MEDICAL EDUCATION AND RESIDENCY

If there is a break in chronology before, during, or after residency training, please describe on a separate page.

Medical Education Graduation Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**A** \_\_\_\_\_  
Type of Residency

Institution \_\_\_\_\_

Location \_\_\_\_\_

From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

**B** \_\_\_\_\_  
Type of Residency

Institution \_\_\_\_\_

Location \_\_\_\_\_

From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

## FELLOWSHIP TRAINING

If there is a break in chronology before, during, or after fellowship training, please describe on a separate page.

**A** \_\_\_\_\_  
Type of Fellowship

Institution \_\_\_\_\_

Location \_\_\_\_\_

From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

**B** \_\_\_\_\_  
Type of Fellowship

Institution \_\_\_\_\_

Location \_\_\_\_\_

From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

## BOARD CERTIFICATION Yes No

Applicants certified by a board other than the American Board of Pediatrics or American Board of Medical Subspecialties must include a photocopy of the certificate of board certification.

**A** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Specialty Board Certification Date (MM/DD/YY)

**B** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Specialty Board Certification Date (MM/DD/YY)

Please check the requirements for the applicable Section/Council before proceeding to Activities Devoted to Pediatrics. Specific Criteria sheets can be viewed at [www.aap.org/member/secriteria.htm](http://www.aap.org/member/secriteria.htm).

## ACTIVITIES DEVOTED TO PEDIATRICS

Indicate what percentage of your professional activities are devoted to pediatric patients.

\_\_\_\_% practice • \_\_\_\_% teaching • \_\_\_\_% research • \_\_\_\_% other (describe) \_\_\_\_\_ = \_\_\_\_% overall percentage

## MILITARY SERVICE

If you are or were in the Uniformed Services, please indicate which branch:  Army  Navy  Air Force  Public Health Service  
What is/was your rank? \_\_\_\_\_ Are you in the reserves?  Yes  No — Are you retired?  Yes  No  
Which local chapter(s) do you wish to join?  Uniformed Services  State Chapter **Please note there may be additional dues for chapter membership.**

## MEDICAL LICENSE

State licensed? \_\_\_\_\_ License # \_\_\_\_\_  
• Has your medical license or hospital privileges ever been revoked, suspended or restricted?  Yes\*  No \*If yes, please detail on a separate page  
• Are you aware of any current inquiry, investigation, complaint, or other proceeding that could result in the revocation, suspension, or restriction of your medical license?  Yes\*  No \*If yes, please detail on a separate page

## DEMOGRAPHIC INFORMATION

This information will remain confidential and will be used to serve members.

### ABOUT YOUR PRACTICE:

During a typical work week, how many hours do you spend in the following professional activities?

Activity	Hours
Direct Care (self-employed)	_____
Direct Care (not self-employed)	_____
Administration	_____
Academic Medicine	_____
Research	_____
Resident	_____
Fellowship Training	_____
Temporarily Not in Practice	_____
Other: _____	_____

Total hours per week: \_\_\_\_\_

Indicate your primary employment setting, the setting in which you spend the MOST time.

- Solo/Two-physician practice
- Pediatric/Multispecial group practice
- Staff Model HMO
- Medical school or parent university
- Government hospital/clinic
- Non-government hospital/clinic
- Retired
- Other: \_\_\_\_\_

Describe your primary practice area. Is it...

- Urban, inner city
- Urban, non-inner city
- Suburban
- Rural
- Other: \_\_\_\_\_

### ABOUT YOU:

#### Ethnic/Cultural Group

- African American/Black
- Asian or Pacific Islander
- Hispanic
- Native American or Alaskan Native
- White, Non-Hispanic
- Other: \_\_\_\_\_

## APPLICANT SIGNATURE

I hereby certify that all information recorded on this application and any attached documents are accurate and support my qualifications for membership in the Academy for which I now apply.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

If the Academy learns that any information in your application is untrue, or if circumstances change after the date of application that affect ethical and professional standards, it may be grounds for suspension or revocation of membership. The American Academy of Pediatrics does not adopt any practice, policy, or procedure which would result in discrimination on the basis of race, religion, creed or health status for membership. Cancellation of membership must be submitted in writing and cannot be granted retroactively.

### PAYMENT — To pay your 12 month dues payment, please complete below.

1st Year Specialty Fellow Membership (\$544 less 50% 1st year discount) \$ 272.00

Section/Council (Name) \_\_\_\_\_ \$ \_\_\_\_\_  
(visit [www.aap.org/member/secriteria.htm](http://www.aap.org/member/secriteria.htm))

Chapter (Name) \_\_\_\_\_ \$ \_\_\_\_\_  
(visit [www.aap.org/member/chapters/chapfacts.htm](http://www.aap.org/member/chapters/chapfacts.htm))

**Total** (Canadian Residents are subject to applicable tax) \$ \_\_\_\_\_

My check for \$ \_\_\_\_\_ is enclosed — Check # \_\_\_\_\_ (Make check payable to: American Academy of Pediatrics)

I will pay using the following credit card:  Visa  Mastercard  Amer Express  Discover

Amount \$ \_\_\_\_\_ Cardholder Name \_\_\_\_\_

**Include the 3-digit CVV# located on the signature space of your card.**

Card # \_\_\_\_\_ CVV# \_\_\_\_\_ Exp. Date \_\_\_\_\_ / \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### RETURN APPLICATION TO:

AAP, Division of Member Services & Relations • 141 Northwest Point Blvd. • Elk Grove Village, IL 60007 **OR** Fax: 847/228-7035

**PAYMENT MUST ACCOMPANY APPLICATION FOR PROCESSING**