

# SECTION ON PERINATAL PEDIATRICS AFFILIATE APPLICATION

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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

## INFORMATION (please print)

### FOR AAP USE ONLY

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

DIST \_\_\_\_\_

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

MD  DO  NNP  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 email address

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

Fax \_\_\_\_\_

I AM APPLYING FOR AFFILIATE MEMBERSHIP IN PERINATAL PEDIATRICS (\$75).

## SECTION MEMBERSHIP CRITERIA

- Licensed physicians (DO's and MD's) who are not otherwise eligible for membership in the American Academy of Pediatrics but who have a special interest in Perinatal Pediatrics.
- Licensed Healthcare Providers practicing in fields associated with perinatal pediatrics (such as nurses, advanced nurse practitioner, nurse midwives, social workers, respiratory therapists).

**Affiliate applicants must submit copy of license.**

**BOARD/PROFESSIONAL CERTIFICATION (if applicable)** Please provide copy(ies) of certificate(s).

Board \_\_\_\_\_

Sub-Board \_\_\_\_\_

## CURRENT HOSPITAL AFFILIATION/PLACE OF EMPLOYMENT

## CURRENT MEDICAL SCHOOL APPOINTMENT (if applicable)

## CURRENT PROFESSIONAL ACTIVITIES (private practice, industry or government positions, university, etc.)

## 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

CONTINUED

## AREAS OF SPECIAL INTEREST

Indicate areas of special interest pertaining to the Section/Council you are applying to:

What activities would you be interested in assisting the Section/Council with (newsletter, educational programming, etc.)?

## GRADUATE MEDICAL EDUCATION (if applicable)

Type	Institution	Location	From (MM/DD/YY)	To (MM/DD/YY)
_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	____/____/____	____/____/____

## HONORS

## SOCIETY MEMBERSHIPS Please include city, state, zip, phone number.

## PUBLICATIONS (attach additional sheets if necessary)

## TIME SPENT IN FIELD

Report percent of time spent in field related to the Section/Council for which you are applying. Describe hours per week devoted exclusively to pediatrics within specialty, i.e., number of hours in clinic, teaching, research, private practice, etc.

Activity	Hours Per Week	% Of Time
_____	_____	_____
_____	_____	_____

## 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.

Section/Council (Name) **PERINATAL PEDIATRICS** \$ 75.00  
(visit [www.aap.org/member/secriteria.htm](http://www.aap.org/member/secriteria.htm))

**Total** (Canadian Residents are subject to applicable tax) \$ **75.00**

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 COMPLETED APPLICATION TO:

AAP, Division of Member Services & Relations • 141 Northwest Point Boulevard • Elk Grove Village, IL 60007  
Phone: 800/433-9016 • Fax: 847/228-7035 • Email: [membership@aap.org](mailto:membership@aap.org) • [www.aap.org](http://www.aap.org)

**PAYMENT MUST ACCOMPANY APPLICATION FOR PROCESSING**