Member Application
AAP National Affiliate
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

SPAP Fellow
AAP Membership

Mission
The mission of the American Academy of Pediatrics (AAP) 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.

AAP Benefits & Privileges
- AAP News, the official news magazine of the AAP
- Pediatrics (online), the official journal of the AAP
- eBreaking news alerts and AAP News OnCall
- Federal Advocacy Action Network (FAAN)
- Red Book Online: Report of the Committee on Infectious Diseases
- MyAAP, instant access to benefits, resources, and involvements
- Pedialink®, your online center for lifelong learning
- Council/section membership in accordance with bylaws
- Opportunity to serve on National Committees
- Listing in the Online Membership Directory
- Discount on National Conference and Exhibition, a multi-day conference
- Discounts at AAP BookStore, your source for the best in pediatrics
- Variety of member affinity programs from car rental to insurance

AAP National Affiliate Membership dues are $206/year.

SPAP Membership

Mission
The mission of the Society for Physician Assistants in Pediatrics (SPAP) is to improve the health care of children by supporting Physician/PA teams who provide cost effective, quality care to pediatric patients and by promoting a network for communication and education between providers dedicated to the well being of children.

Top 10 Reasons to Join SPAP
- The only constituent organization dedicated to promoting PAs in pediatrics
- Discount on Annual CME Conference
- Leadership opportunities in a growing organization
- Access to pediatric employment opportunities
- Contact with SPAP and AAPA liaisons to the AAP
- Support, guidance, and education for supervising MDs, clinics, and hospitals
- Discounts on industry publications for members
- Discounted PA courses for members
- Networking with peers across the profession
- Advocacy for children and the profession

SPAP Fellow Member dues are $75/year.

AAP/SPAP Dual Membership
The AAP and SPAP have formed a partnership to recognize the important role physician assistants play in the physician-directed, team-based approach to care. Through this partnership, PAs have the opportunity to join both organizations for only $206/year* - more than a 25% savings!

*Please note, this is a special offer only to PAs joining both organizations for the first time.

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 affects 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, the AAP receives compensation for providing the information, or when members participate 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.

For more information, contact:
AAP, Division of Member Services & Relations
800/433-9016 • 847/434-4000 • msupdates@aap.org

Benefits are subject to change.
Membership Application

National Affiliate / SPAP Fellow

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

INFORMATION (please print)

First Name                        Middle/Maiden                        Last

☐ PA-C  ☐ Other (specify) _________  ☐ Male ☐ Female

Date of Birth (MM/DD/YY)

Office Address & Phone

☐ Check if this is preferred mailing address

Practice/Organization Name

Title

Number/Street/Suite

City/State

Zip/Postal Code/Country

Telephone

Preferred contact number

Business Email

Fax

Preferred email address

Website

Supervising Doctor’s Name/Email

PHYSICIAN ASSISTANT TRAINING

A

Institution

Location

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

B

Institution

Location

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

MEDICAL LICENSE

States Licensed in: ____________________________ 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

CERTIFICATION Include photocopy(ies) of the certificate(s) with application.

☐ National Commission on Certification of Physician Assistants

Certification Date (MM/DD/YY) _______/______/_______

NCCPA ID Number__________________________

Would you like to speak at future SPAP conferences? ☐ Yes ☐ No
PROFESSIONAL MEMBERSHIPS
- American Academy of Physician Assistants
- Society for Physician Assistants in Pediatrics
- Other

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

Indicate your primary employment setting:
- Pediatric Group Practice
- Multi-specialty Group Practice
- Solo/Two-Physician Practice
- Academic Institution (i.e. medical school)
- Hospital/Clinic
- Non-practice Industry
- Non-practice Government

In these activities combined, do you:
- Work less than 40 hours/week
- Work 40 hours/week or more
- Currently not in practice

Indicate your specialty:
- General Pediatrics
- Specialty

Describe your primary practice location:
- Urban, inner city
- Urban, non-inner city
- Suburban
- Rural

Ethnicity/Race
- Black/African American
- Asian
- Pacific Islander
- Hispanic/Latino
- Native American or Alaskan Native
- White/Caucasian
- Middle Eastern
- Indian
- Other

SPONSOR SIGNATURE
Sponsor must be an AAP Fellow or Specialty Fellow in good standing.
I, ______________________, approve and support this applicant to become a National Affiliate Member of the AAP.
Sponsor Signature ______________________ Date ____________
Print Name ______________________ AAP# ____________ City & State ____________

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.
- AAP National Affiliate Member - $185.40 if already an SPAP Member, $206 if not an SPAP Member
- AAP/SPAP Combined Membership - $206 *Special offer to PAs joining both organization for the first time
- AAP Council/Section (Name)
  To join a council/section visit www.aap.org/member/seccriteria.htm and then list the name(s) above with dues amount.
- AAP Chapter (Name)
  To join a chapter visit www.aap.org/member/chapters/chapfacts.htm and then list the chapter(s) above with dues amount.
 total (Canadian Residents are subject to applicable tax) $ ____________

- Attached is a copy of NCCPA certification and medical license.
- 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 __________________________
Card # ____________________________ Exp. Date ________ / ________ Billing Zip Code ____________
Signature __________________________ Date ____________

Referred by: ______________________ City/State: ______________________

RETURN APPLICATION TO:
AAP, Division of Member Services & Relations • 72103 Eagle Way • Chicago, IL 60678-7251 OR Fax: 847/228-7035
PAYMENT MUST ACCOMPANY APPLICATION FOR PROCESSING