



American Academy of Pediatrics California Chapter 1

Application for Associate Membership

(Please print or type)

Name: _____ Date: _____

Street: _____ Phone: () _____

City/State/Zip: _____ Fax: () _____

E-Mail: _____

Degree: _____
(DDS, PhD, MS, LCSW, RN, PNP, PHN, NP, etc)

Associate Fellow of AAP: Yes No Date: _____

I am interested in receiving information on or joining the following committee(s):

- | | |
|---|---|
| <input type="checkbox"/> Behavioral/Developmental Pediatrics/Disabilities | <input type="checkbox"/> Child Abuse |
| <input type="checkbox"/> Early Childhood Adoption & Depndent Care | <input type="checkbox"/> Environmental Health |
| <input type="checkbox"/> Medical Education | <input type="checkbox"/> Membership |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> School Health |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Vintage Docs |
| <input type="checkbox"/> Young Physicians/Associates | <input type="checkbox"/> Youth |

Please return this application along with your check for \$160
annual dues made payable to CC1, AAP to:
California Chapter 1, AAP
68 Mitchell Blvd. #252
San Rafael, CA 94903
415/479-9200
Fax: 415/479-9202
E-Mail: aapbev@sbcglobal.net
www.aapca1.org

Your application will be presented to the Chapter 1 Board of Directors for approval
and you will be notified of your acceptance by mail.