

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



California Chapter 1

APPLICATION FOR MEMBERSHIP

(Please type or print)

Name: _____ Date: _____

Street: _____ Phone: () _____

City: _____ State: _____ Zip: _____

E-Mail: _____ Fax: () _____

Medical School: _____ MD (Year) _____

Internship Location: _____ Date: _____

Residencies &
Fellowships: _____ Date: _____

_____ Date: _____

Type of Practice or
Academic Medicine: _____

Board Certified? Yes No Date: _____

AAP Fellow? Yes No Date: _____

Member of _____ County Medical Society

Are you currently in a Residency or Training Fellowship and applying for Resident or Post-Residency Training Fellow membership? (No dues are paid by Residents or Post-Residency Training Fellows) Yes No

Applicant must have one sponsor who is a member of California Chapter 1, American Academy of Pediatrics

Sponsor: _____

(Signature)

Please return this application, along with your **check for \$160**
annual dues made payable to CCI, AAP, to:

California Chapter 1
American Academy of Pediatrics
68 Mitchell Blvd., #252
San Rafael, CA 94903
(415) 479-9200 Fax: (415) 479-9202
aapbev@sbcglobal.net
www.aapca1.org