**GEORGIA CHAPTER**  
**American Academy of Pediatrics**  
**CHAPTER MEMBERSHIP APPLICATION**  
*Please notify the office when your contact information changes! Thanks.*

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
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</table>

**Designation:**
- [ ] MD  
- [ ] DO  
- [ ] DDS/DMD  
- [ ] PNP  
- [ ] RN  
- [ ] Other

**Mailing Address (Office):**

City__________________________ State_____ Zip + 4 _____________ - ______ County________________

**Mailing Address (Home):**

City__________________________ State_____ Zip + 4 _____________ - ______ County________________

**Phone________________________  Is this [ ] home or [ ] work?**

**Fax________________________  Email_________________________________________________________**

**Practice/Hospital/Institution Name (If Applicable):**

__________________________________________________________

**Office Manager/Assistant:**

__________________________________________________________

**Date of Birth__________________________  [ ] Male  [ ] Female  AAP ID_______________________**

Please indicate your training:
- [ ] A) Primary Care Pediatrics
- [ ] B) Pediatric Subspecialty *(Please indicate below)*
- [ ] C) Other

- [ ] Adolescent Medicine  
- [ ] Allergy & Immunology  
- [ ] Anesthesiology  
- [ ] Cardiology  
- [ ] Child Abuse  
- [ ] Critical Care  
- [ ] Dentistry (Pediatric)  
- [ ] Dermatology  
- [ ] Developmental/Behavioral Pediatrics  
- [ ] Emergency Medicine  
- [ ] Endocrinology  
- [ ] Gastroenterology  
- [ ] Genetics  
- [ ] Hematology/Oncology  
- [ ] Hospice & Palliative Medicine  
- [ ] Infectious Diseases  
- [ ] Med/Peds  
- [ ] Medical Toxicology  
- [ ] Neonatal/Perinatal Pediatrics  
- [ ] Nephrology  
- [ ] Neurodevelopmental Disabilities  
- [ ] Neurology  
- [ ] Ophthalmology  
- [ ] Orthopedics  
- [ ] Otolaryngology  
- [ ] Plastic Surgery  
- [ ] Psychiatry  
- [ ] Pulmonology  
- [ ] Radiology  
- [ ] Rehabilitation Medicine  
- [ ] Rheumatology  
- [ ] Sleep Medicine  
- [ ] Sports Medicine  
- [ ] Surgery  
- [ ] Transplant Hepatology  
- [ ] Urology  
- [ ] Other

*Please turn application over & continue*
Please indicate your **PRIMARY** type of practice or employment:

- A) Academic
- B) Hospital based *(Includes administration and/or patient care)*
- C) Managed Care *(Includes administration and/or patient care)*
- D) Military
- E) Private Practice *(Solo)*
- F) Private Practice *(Group – 2 or more)*
- G) Public Health *(State or Local)*
- H) Public Health *(Federal)*
- I) Other *(please specify)______________________________*

**Categories of Chapter Membership:**

<table>
<thead>
<tr>
<th>Category</th>
<th>DUES</th>
<th>CODE</th>
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<tbody>
<tr>
<td>Fellow <em>(Fellow, American Academy of Pediatrics)</em></td>
<td>$205</td>
<td>(00)</td>
</tr>
<tr>
<td>Specialty Fellow <em>(Specialty other than Pediatrics)</em></td>
<td>$205</td>
<td>(02)</td>
</tr>
<tr>
<td>Resident Fellow <em>(Resident program in Georgia)</em></td>
<td>$0</td>
<td>(03)</td>
</tr>
<tr>
<td>Chapter Affiliate <em>(Chapter member, but non-member of AAP)</em></td>
<td>$205</td>
<td>(20)</td>
</tr>
<tr>
<td>Candidate Fellow <em>(Maximum 7 years – post residency)</em></td>
<td>$150</td>
<td>(30)</td>
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<tr>
<td>Post Residency Training Fellow</td>
<td>$80</td>
<td>(40)</td>
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<tr>
<td>Senior Members <em>(65 years of age or older &amp; retired from active practice)</em></td>
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<td>(05)</td>
</tr>
<tr>
<td>Associate Member <em>(Pediatric Dentist)</em></td>
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<td>(79)</td>
</tr>
<tr>
<td>Associate Affiliate <em>(Nurses, NPs, PAs, etc.)</em></td>
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<td>(89)</td>
</tr>
<tr>
<td>Medical Students <em>(Medical school in GA)</em></td>
<td>$0</td>
<td>(88)</td>
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- Payment Enclosed
- Please send me an invoice for Chapter Dues

Please charge my Credit Card

Choose one:

- MasterCard
- Visa
- American Express

Card Number__________________________________________  Exp.__________________

Name on Card_________________________________________  CVV code: ______________

Signature______________________________________________________________________________

Are you interested in serving on a chapter committee?  □Yes □ No
If yes, please list any committees in which you are interested______________________________________________

Please list areas of professional interest and additional expertise______________________________________________

**Please return to:**  
Georgia Chapter/American Academy of Pediatrics  
Attn: Membership  
1350 Spring Street, Suite 700, Atlanta, GA 30309  
Phone: 404/881-5067 Fax: 404/249-9503  
asmith-adams@gaaap.org

June 2024