# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

FOR AAP USE ONLY/ONLINE
AAP ID# ____________________
DISTRICT ____________________
CHAPTER ____________________

First Name ________ Middle/Maiden ________ Last Name ________ ❑MD ❑DO ❑Other (specify) ________

________________________ ❑Male ❑Female _ _ _ _ /_ _ _ _ _ /_ _ _ _ _
Date of Birth (MM/DD/YY) Social Security Number

**Preferred Address & Phone** ❑Home –or– ❑Office

________________________________________
Organization Name (if applicable)

________________________________________
Number/Street/Suite

________________________________________
City/State/Zip or Postal Code/Country

____________________ ____________________
Telephone Cellular

________________________________________
Email

**I AM APPLYING FOR CHAPTER MEMBERSHIP IN CALIFORNIA CHAPTER 4 (ORANGE COUNTY)**
**DUES RATE - $195**
**FOR FIRST TWO YEARS AFTER RESIDENCY - $95**
**AFFILIATE - $145**

## FELLOWSHIP TRAINING

________________________________ ____/____/____ ____/____/____
________________________________ From (MM/DD/YY) To (MM/DD/YY
Type of Fellowship Institution

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

________________________________________
________________________________
Board or Sub-Board Certificate Date

## MILITARY SERVICE

If you are or were in the Uniformed Service, 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

## 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 AAP California Chapter 4 for which I now apply.

Signature of applicant________________________________Date________________

**PAYMENT** To pay your Chapter dues rate provide the following information below.

❑ My check for $____________ is enclosed – Check #____________________

❑ I will pay using the following credit card: ❑ Visa ❑ Mastercard ❑ AMEX ❑ Discover

Amount $____________ • Cardholder Name________________________________________
Card # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ • **CVV#** __ __ __ • Exp. Date _______ /_______
Signature ________________________________Date ________________

**RETURN APPLICATION TO:**
California Chapter 4 AAP (Orange County) • 17322 Murphy Ave • Irvine, CA 92614 **– or –** Fax to: 949/752-2788

**PAYMENT MUST ACCOMPANY APPLICATION FOR PROCESSING**