

Tennessee Chapter of the
American Academy of Pediatrics
Tennessee Pediatric Society

P.O. Box 159201
Nashville, Tennessee 37215
(615) 383-6004; Fax: (615) 383-7170
e-mail: Info@tnaap.org web site: www.tnaap.org



MEMBERSHIP APPLICATION

PART I:

NAME _____

ADDRESS _____

CITY _____ ZIP _____ Is this Home or Work? _____

COUNTY of Home _____ COUNTY of Work _____

PHONE: (W) _____ (H) _____ (FAX) _____

EMAIL _____ PRACTICE NAME (If Applicable) _____

CATEGORY OF MEMBERSHIP (*Membership in AAP automatically qualifies you for TNAAP/TPS membership*)

- | | |
|--|-----------------|
| <input type="checkbox"/> FELLOW (<i>Physician who is FAAP-designated</i>) | Dues: \$ 165 |
| <input type="checkbox"/> SPECIALTY FELLOW (<i>AAP member who is certified by boards of another medical society</i>) | Dues: \$ 165 |
| <input type="checkbox"/> CHAPTER AFFILIATE (<i>Any physician not a Fellow of the AAP. Must complete Part II.</i>) | Dues: \$ 165 |
| <input type="checkbox"/> CANDIDATE FELLOW (<i>Limited to 4-year period post-residency for members of AAP</i>) | Dues: \$ 165 |
| <input type="checkbox"/> EMERITUS OR RETIRED FELLOW | Dues: \$ 35 |
| <input type="checkbox"/> POST-RESIDENCY TRAINING FELLOW (<i>AAP must have letter from fellowship program director</i>) | Dues: \$ 50 |
| <input type="checkbox"/> RESIDENT FELLOW (<i>Pediatric resident who belongs to the AAP</i>) | Dues: No Charge |
| <input type="checkbox"/> ASSOCIATE MEMBER (<i>Pediatric dentists</i>) | Dues: \$ 165 |
| <input type="checkbox"/> CHAPTER AFFILIATE (<i>Allied Health Professional</i>) Indicate Designation _____ | Dues: \$ 85 |

Sub-Specialty (if any) _____

Primary Work: private academic hospital public health admin. mngmt gov

Time Devoted to Pediatrics full-time part-time other (explain)

Advocacy Area(s) of Interest _____

(National AAP members need not complete this section)

PART II: ACADEMIC HISTORY (List institution and dates attended.)

Medical School _____

Internship _____

Residency _____

Fellowship _____

Hospital Affiliation _____

Board Certified yes no

Medical Society Memberships _____

SPONSOR NAME _____ PHONE NUMBER _____

(Sponsor must already be TNAAP/TPS member)

APPLICANT SIGNATURE _____ DATE _____

***Your check for dues must accompany this application.**

(Please make checks payable to National AAP)

DUES ENCLOSED: _____

Rev: July 2011