

**Tennessee Chapter of the  
American Academy of Pediatrics  
Tennessee Pediatric Society**



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Nashville, Tennessee 37215  
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**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: \$ 150    |
| <input type="checkbox"/> SPECIALTY FELLOW ( <i>AAP member who is certified by boards of another medical society</i> )    | Dues: \$ 150    |
| <input type="checkbox"/> CHAPTER AFFILIATE ( <i>Any physician not a Fellow of the AAP. Must complete Part II.</i> )      | Dues: \$ 150    |
| <input type="checkbox"/> CANDIDATE FELLOW ( <i>Limited to 4-year period post-residency for members of AAP</i> )          | Dues: \$ 135    |
| <input type="checkbox"/> EMERITUS FELLOW ( <i>Retired</i> )                                                              | 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, PNP's, RN's, etc.</i> )                               | Dues: \$150     |

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 \_\_\_\_\_

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*(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.**

DUES ENCLOSED: \_\_\_\_\_

June 2006