AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

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MEMBERSHIP APPLICATION

First Name:______________________________Last Name: ___________________________MI:________

❒ Male ❒ Female   Preferred Contact Address: ❒ Mailing ❒ Billing

Mailing Address: ___________________________   Billing Address: ___________________________
City: ___________________________   City: ___________________________
State/Country:__________Zip/Postal Code:__________   State/Country:__________Zip/Postal Code:__________
Phone:______________Fax:______________   Phone:______________Fax:______________

E-mail:_____________________________ Address to be published in directory or web site? ❒ Mailing ❒ Billing ❒ Neither
Secondary E-mail:_____________________________ AOA #:______________ AAP#: ______________

Note: The ACOP does not provide member phone/email information to outside vendors. Please supply your email address to expedite important ACOP communications in a more timely and cost effective method.

DOCTORAL AND POSTDOCTORAL TRAINING

All applications are reviewed by the ACOP Membership Committee and Board of Trustees. Please allow 3-4 weeks for the approval process and to receive confirmation in writing. Please note: Failure to provide a completed membership application (including information below) may result in denial of membership in the ACOP.

Undergraduate Education: ___________________________ Location: ___________________ Dates: __________
Graduate Education: ___________________________ Location: ___________________ Dates: __________
Osteopathic Medical School ___________________________ Location: ___________________ Dates: __________
Internship Institution:___________________________ Location: ___________________ Dates: __________
Residency/Fellowship Institution: ___________________________ Location: ___________________ Dates: __________
Are you board eligible? ❒ Yes ❒ No ___________________ Are you board certified? ❒ Yes ❒ AOBP ❒ ABP ❒ No
Academic Affiliation(s): ____
Hospital Staff Positions Currently Held:____
Primary Institutions and Locations:____

Specialty: ❒ Adolescent Medicine ❒ Allergy/Immunology ❒ Child Neurology ❒ Emergency Medicine ❒ Family Medicine ❒ Gastroenterology ❒ General Pediatrics ❒ Hospitalist ❒ Internal Medicine ❒ Med/Pediatrics ❒ Neonatology ❒ OMM - Peds & Adults ❒ Pediatric ❒ Endocrinology

If accepted for membership, I agree to abide by the Code of Ethics and the Constitution and Bylaws of ACOP. By Submission of this document, I authorize release of the information contained herein and in membership files of those organizations and hospitals to which I may subsequently apply for membership, and the release to ACOP by organizations and hospitals of information relative to my previous membership in those organizations. I am a resident or a licensed physician in compliance with the state board of medical licensure and/or discipline's order.

Signature: ____ Date: ____________________

MEMBERSHIP CRITERIA

Fellow

Licensed osteopathic physicians certified in pediatrics by the American Osteopathic Board of Pediatrics or the American Board of Pediatrics. Fellows may vote on all governance issues, hold elective office, and serve on all ACOP committees.

Associate

Licensed osteopathic physicians who have completed a pediatric training program acceptable to the ACOP Executive Council. Associate members may vote on all governance matters, hold elective office, and serve on all ACOP committees.

General

Licensed osteopathic physicians who have a personal interest in pediatrics. General members may not vote or hold elective office, but may serve on all ACOP committees.

Candidate

(Intern/Resident/Fellow-in Training)

Interns, Residents or Fellows-in-Training participating in an approved training program. Candidate members may not vote or hold elective office, but may serve on all ACOP Committees.

Student Membership: Students must complete the Student Membership Application.

All applicants will be reviewed by ACOP, and applicants will receive prompt notice when approved. The process takes approximately two months.

❒ Fellow*.................................... $400
❒ Associate $400
❒ General $400
❒ Intern**.............................$25 End Date ________
❒ Resident** ....$25 End Date ________
❒ Fellow-in-Training**...............$30 End Date ________

***Please provide: Copy of state license and proof of board certification, if applicable.**
****For Interns, Residents and Fellows-in-Training: Note from program director indicating participation in a training program.**

Payment Options (Please do not send cash for payment)

❒ Check or Money Order Enclosed (US Funds) Made Payable to: ACOP, 2209 Dickens Rd., Richmond, VA 23230-2005.
If paying by check, you MUST include a copy of this application with your payment.

❒ AmEx ❒ Mastercard ❒ Visa ❒ Discover Card Number: ___________________________
Printed Name on Card ___________________________ Exp. Date ______________
Billing Address ___________________________ Zip Code __________
Signature ___________________________ CVV Security Code* ______________

**CVV code is the three digit number on the back of VISA or MC or 4 digit number on the front of AMEX card above the account number.*