

LOUISIANA CHAPTER
AMERICAN ACADEMY OF PEDIATRICS

P. O. Box 64629
Baton Rouge, LA 70896
Ph. 225/925-7239 Fax 225/925-1771
http://www.laaap.org

MEMBERSHIP APPLICATION

Date: _____

PART I

Name: _____ Birth Date: _____
Office Address: _____
City, State, Zip: _____
Office Phone: _____ Home Phone: _____ Fax: _____
E-Mail Address _____

Category of Membership (*Membership in AAP automatically qualifies you for LA-AAP membership*):

- | | |
|---|-----------|
| <input type="checkbox"/> Fellow (<i>Physicians who are members of the AAP</i>) | \$200.00 |
| <input type="checkbox"/> Specialty Fellow (<i>AAP members who are certified by boards of other medical specialties</i>) | \$200.00 |
| <input type="checkbox"/> Candidate Fellow (<i>Limited to 4-year period post-residency training for pediatricians who are members of the AAP</i>) | \$50.00 |
| <input type="checkbox"/> Post Residency Fellow (<i>AAP members who are in fellowship training</i>) | \$50.00 |
| <input type="checkbox"/> Resident Fellow (<i>Pediatric resident who belongs to the AAP</i>) | No Charge |
| <input type="checkbox"/> Chapter Affiliate (<i>**Any physician whose professional activity is primarily in pediatrics but who is not a Fellow of the AAP**</i>) PLEASE COMPLETE PART II OF THIS APPLICATION | \$200.00 |

Dues Enclosed: _____

Please mail application to:

Membership
Louisiana Chapter
American Academy of Pediatrics
P. O. Box 64629
Baton Rouge, LA 70896

FOR CHAPTER AFFILIATE APPLICANTS ONLY

PART II

Education (*List institution and dates attended*):

Premedical: _____
Medical: _____
Internship/Residency: _____
Fellowship: _____
Board Certification: _____

Primary Work Commitment (*Circle One*): Private Practice Military Academics Public Health
% of Professional Time Devoted to Pediatrics: _____

Medical Society Memberships: _____

