CHAPTER AFFILIATE APPLICATION

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Kentucky Chapter

FOR AAP USE ONLY/ONLINE
AAP ID# _____
DISTRICT IV
CHAPTER KENTUCKY

_____ _____ ❑ Male ❑ Female
First Name Middle/Maiden Last Name

❑ MD ❑ DO ❑ Other (specify) _____ Date of Birth _ _ /_ _ /_ _ _ _

Preferred Address & Phone ❑ Home –or– ❑ Office

_____
Organization/Practice Name (if applicable)

_____
Number/Street/Suite

_____
City/State/Zip County

_____ _____ _____
Telephone Cellular Email

I AM APPLYING FOR CHAPTER MEMBERSHIP IN KENTUCKY CHAPTER

❑ I am a member of the AAP (national) ❑ I am a NEW Chapter member ❑ I am a returning (lapsed) Chapter member

KY CHAPTER DUES RATES:

Fellow, Candidate Fellow and Specialty Fellow - **$150**
Associate (Dentist), Non-Ped Physician Chapter Affiliate - **$125**
Allied Health Professional Chapter Affiliate - **$75**
Resident, Emeritus, Student - **$0**

FELLOWSHIP TRAINING

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

BOARD/PROFESSIONAL CERTIFICATION (if applicable)

_____ _____
Board or Sub-Board Certificate Date

APPLICANT SIGNATURE

I hereby certify that all information recorded on this application is accurate and support my qualifications for membership in the AAP Kentucky Chapter for which I now apply.

Signature of applicant_____
Date_____

PAYMENT To pay your KY Chapter dues payment, please complete below.
❑ My check for $_____ is enclosed – Check #_____
❑ I will pay using the following credit card: ❑ Visa ❑ Mastercard ❑ AMEX ❑ Discover **Include the 3-digit CVV# located on the back of your card.**
Amount $_____ • Cardholder Name_____
Card # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ • **CVV#** __ __ __ • Exp. Date _____ /_____

Signature _____ Date _____

RETURN APPLICATION TO:

Kentucky Chapter of the AAP, 420 Capital Ave., Frankfort, KY 40601 502.875.2205 FX 502.223.4200

PAYMENT MUST ACCOMPANY APPLICATION FOR PROCESSING