APPLICATION FOR MEMBERSHIP
WEST VIRGINIA CHAPTER
AMERICAN ACADEMY OF PEDIATRICS

Date_____

Please print or type

Name_____
(First) (Middle) (Last)

Office Address_____

City_____State_____Zip Code_____

Phone_____E-Mail_____Fax_____

Education

College_____Date_____Degree_____

Medical School_____Year Graduated_____

Internship_____Dates_____

Residency_____Dates_____

Residency_____Dates_____

Fellowship (Specialty)_____Dates_____

Percentage of time devoted to Pediatrics_____

Hospital staff appointment(s)_____

Are you a member of the national AAP? _____Yes _____No

Medical School, teaching or research appointments_____

Public Health positions_____

Other activities related to Pediatrics_____

Certified by American Board of Pediatriccs?_____Year_____Recertified_____

SubBoard_____Year_____

Medical Societies: County_____State_____AMA_____

Service in Armed Forces? Branch_____

Dates_____Rank_____

Particular Areas of Interest_____