AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

2209 Dickens Rd., Richmond, VA 23230-2005 • Phone: 804-565-6333 • Fax: 804-282-0090
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MEMBERSHIP APPLICATION

First Name:_____Last Name: _____MI:_____

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

Mailing Address: _____
City: _____
State/Country:_____Zip/Postal Code:_____
Phone:_____Fax:_____

Billing Address:_____
City: _____
State/Country:_____Zip/Postal Code:_____
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 provie 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_____Subspecialty _____

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 in 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**.....$20 End Date _____
❒ Resident** .....$30 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 Fellow-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.*