



TEXAS ACADEMY OF PSYCHIATRY

Advocates for Patients and Quality Psychiatric Care

MEMBERSHIP APPLICATION

I am applying for membership in the Texas Academy of Psychiatry (Academy).

Please check membership category: (Dues payments will be posted upon approval of membership application)

- Member-in-Training:** I am a physician in a psychiatric residency training program approved by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada or the American Osteopathic Association. Enclosed is my annual dues of \$50.
- General Membership:** I am a physician who has completed acceptable psychiatry training (as approved by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education or the American Osteopathic Association) and I have a valid license to practice medicine or I have an academic, research or governmental position that does not require licensure. Enclosed is my annual dues of \$395.
- Fellow:** I am a physician who has received the designation of Fellow or Distinguished Fellow from the American Psychiatric Association (APA). Year of designation _____. Enclosed is my annual dues of \$395.
- Retired:** I am a physician, fully retired from the practice of medicine in _____. Enclosed is my annual dues of \$150.
- Associate Membership:** I am a physician who is currently a member in good standing with the Texas Society of Psychiatric Physicians (TSPP), a District Branch of the American Psychiatric Association. Enclosed is my annual dues of \$25.

Are you a former member of TSPP? Yes No Are you a former member of the APA? Yes No

1. CONTACT INFORMATION

Last Name	First Name	Middle Initial	Suffix	Degree
Mailing Address		City	State	Zip
Telephone (_____) _____	Fax (_____) _____	Email _____		

2. DEMOGRAPHIC DATA The following categories are for statistical purposes only. This information will not be considered in connection with your application.

Birthdate ____ / ____ / ____

Gender Female Male

3. PRACTICE INFORMATION

Primary Practice Setting:

- Solo Office
- Group Office
- Private General Hospital
- Public General Hospital
- Federal Hospital (VA/Military)
- Private Psychiatric Hospital
- Public Psychiatric Hospital
- Staff or Group-model HMO Clinic
- Private Clinic - Outpatient Facility
- Public Clinic - Outpatient Facility
- Medical School, University
- Nursing Home
- Correctional Facility
- Other _____

4. PROFESSIONAL SERVICE

Current hospital or clinical staff appointments (specify location and years)

Private practice of psychiatry (specify location and years)

Federal Service: Armed Forces/NHSC

Branch	Rank	Dates of Service
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5. DOCUMENTATION

Please check all that apply. (To avoid unnecessary delay, be sure to submit appropriate documentation).

- License Enclosed.** A photocopy of my current, valid medical license is enclosed with my application and dues.
- E.C.F.M.G. Certificate Enclosed.** I am a graduate from an international medical school. A photocopy of my certificate is enclosed with my application and dues.
- Residency Training Completion Certificate Enclosed.** A photocopy of my residency training completion certificate is enclosed with my application and dues.
- Not Required.** I am a resident, or a physician in an academic, research or governmental position not requiring a license. Enclosed is my application and dues.

6. ACADEMIC TRAINING

Medical School

 School

 City/State or Country

 Started (Mon/Yr) Finished or Expected (Mon/Yr) Degree

Psychiatric Residency Training (and other medical specialty training, including fellowship programs. List the most recent training first.)

 Training Program/School

 City/State or Country

 Started (Mon/Yr) Finished or Expected (Mon/Yr) Specialty

 Training Program/School

 City/State or Country

 Started (Mon/Yr) Finished or Expected (Mon/Yr) Specialty

Psychiatric Residency Endorsement Members-in-Training must have the following endorsement signed by his/her training director.

ENDORSEMENT: I RECOMMEND THE ABOVE APPLICANT FOR MEMBERSHIP IN THE ACADEMY AND CERTIFY THE APPLICANT'S PSYCHIATRIC TRAINING AS LISTED ABOVE.

 Signature (Director of Training) Date

 Name of Training Program/Institution

Training

Does the preceding training information reflect recognized completion of residency training in psychiatry approved by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada or the American Osteopathic Association?

Yes No

If YES, how many full years of psychiatry residency training have you had? _____

Does the preceding training information reflect recognized completion of residency training in a field other than psychiatry? Yes No

If YES, what specialty? _____

Does the preceding training information reflect recognized completion of psychoanalytic training? Yes No

Board Certification

<input type="checkbox"/> American Board of Psychiatry and Neurology- General Adult Psychiatry	_____ Mon/Yr /
<input type="checkbox"/> American Board of Psychiatry and Neurology- Child and Adolescent Psychiatry	_____ /
<input type="checkbox"/> American Board of Psychiatry and Neurology- added qualifications in Forensics	_____ /
<input type="checkbox"/> American Board of Psychiatry and Neurology- added qualifications in Geriatrics	_____ /
<input type="checkbox"/> American Board of Psychiatry and Neurology- added qualifications in Addictions	_____ /
<input type="checkbox"/> American Board of Psychiatry and Neurology- Neurology	_____ /
<input type="checkbox"/> American Board of Forensic Psychiatry	_____ /
<input type="checkbox"/> Royal College of Physicians and Surgeons Of Canada- General Adult Psychiatry	_____ /
<input type="checkbox"/> American Osteopathic Board of Neurology and Psychiatry- General Psychiatry	_____ /
<input type="checkbox"/> American Psychoanalytic Association Board Of Professional Standards- Psychoanalysis	_____ /
<input type="checkbox"/> American Psychiatric Association Psychiatric Administration & Management	_____ /
<input type="checkbox"/> Other _____	_____ /

7. ETHICS

Has your license to practice medicine ever been revoked or suspended? Yes No

Are you currently charged with illegal or unethical professional conduct by a regulatory or law enforcement agency or by a professional society? Yes No

Have you ever been found guilty of illegal or unethical professional conduct by a regulatory or law enforcement agency or by a professional society? Yes No

If YES, to any of the three preceding questions, please furnish details in a confidential communication attached with this application.

8. AGREEMENT

I agree to abide by the Bylaws of the Academy. I understand that the Academy may review my information and make inquiries about me and that I am not entitled to, and will not ask for, a disclosure of the replies. I will hold the Academy, members, officers, employees and agents free from all damage and complaint by reason of action taken on this application or by reason of any subsequent action on membership, including the sharing of information about my professional conduct. I pledge myself to standards of ethical practice and conduct specified in the Bylaws of the Academy and in the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. I certify that the above information is accurate, and I understand that inaccurate information can invalidate my applications. My signature means that I agree to the conditions above and contained in this application.

 Signature Date