TEXAS ACADEMY OF PSYCHIATRY

401 West 15th Street, Suite 675, Austin, Texas 78701
Tele: 512/478-0605; Fax: 512/478-5223; Email: TXPsychiatry@aol.com

MEMBERSHIP APPLICATION

I am applying for membership in the Texas Academy of Psychiatry (Academy), as follows:

❒ **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. Annual Dues: $30 first year, $50.00 thereafter.

❒ **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. Annual Dues: $250 first year, $395.00 thereafter.

❒ **Fellow**: I am a physician who has received the designation of Fellow or Distinguished Fellow from the American Psychiatric Association (APA). Year _____. Annual Dues: $250 first year, $395.00 thereafter.

❒ **Retired**: I am a physician who has fully retired from the practice of medicine. Year _____. Annual Dues: $95 first year, $150.00 thereafter.

❒ **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 and/or the Texas Society of Child and Adolescent Psychiatry (TSCAP) a Regional Council of the American Academy of Child and Adolescent Psychiatry. Annual Dues: $25.00.

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.

Birthdate ____/____/_____ **Gender** ❒ Female ❒ Male

3. LICENSURE and TRAINING
Are you licensed to practice medicine in Texas by the Texas Medical Board? ❒ Yes ❒ No Other_____

❒ I completed a residency training program in Psychiatry on _____ at _____.

_____
Signature Date

Please return this application along with your dues payment to: TAP, 401 West 15th Street, Suite 675, Austin, TX 78701

2016