



# TEXAS ACADEMY OF PSYCHIATRY

401 West 15<sup>th</sup> 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: \$0

**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 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: \$50.00.

### 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

If paying by Check, mail to: Texas Academy of Psychiatry, 401 West 15<sup>th</sup> Street, Suite 675, Austin, TX 78701

If paying by Credit Card, email application to: TXPsychiatry@aol.com & once received you will be sent a QB link to pay your dues online.