

# TSPP General Membership Application

Complete online return the completed application by email, mail or fax:

Texas Society of Psychiatric Physicians  
401 West 15th Street #675  
Austin, TX 78701

**Email:**  
tspp@txpsych.org  
**Fax:**  
512-478-5223

Have you been a member of the TSPP before? Yes No If yes, TSPP Member ID (if known): \_\_\_\_\_ Referred by TSPP Member (Name): \_\_\_\_\_

PERSONAL INFORMATION

Family/Last name:	First Name:	Middle Initial:
Other last names Used Professionally: (for verification purposes only)	Country of Birth:	Date of Birth: MM/DD/YYYY
Office Phone: (Area code/number):	Home Phone: (Area code/number):	Gender:
Fax Number (Area code/number):	Cell/Mobile (Area code/number):	Degree: M.D. D.O. M.B.B.S.
Primary Email:	Secondary Email:	

MAILING ADDRESS

PRIMARY MAILING ADDRESS		SECONDARY MAILING ADDRESS	
Home	Office	Home	Office
Street Address:		Street Address:	
Street Address (Line 2):		Street Address (Line 2):	
City:	State/Province:	City:	State/Province:
Country:	Zip/ Postal Code:	Country:	Zip/ Postal Code:

EDUCATION

Medical School (Required):	<b>PSYCHIATRY RESIDENCY TRAINING (REQUIRED)</b>		
University/School Name:	Training Program/School Name:		
City:	State:	Country:	City/ State, Country:
Degree:	Begin Date: MM/YYYY	Completion: MM/YYYY	Begin Date: MM/YYYY      Completion: MM/YYYY

FELLOWSHIP/ADDITIONAL TRAINING (IF APPLICABLE)	ETHICS (REQUIRED)	
Training Program/School Name:	Has your license to practice medicine ever been revoked or suspended?	Yes No
City:	Are you currently charged with illegal or unethical professional conduct by a regulatory or law enforcement agency or by a professional society?	Yes No
State:	Have you ever been sanctioned or held liable by a regulatory body or court or sanctioned by a professional society?	Yes No
Country:	<i>If you responded YES to any of the three preceding questions, please furnish details in a confidential communication by email to tsppofc@aol.com.</i>	

BOARD CERTIFICATION	CERTIFICATION DATE - VALID THRU DATE	RESIDENCY TRAINING VERIFICATION
American Board of Psychiatry and Neurology:	MM/YYYY    MM/DD/YYYY	A certificate of residency training completion is required, unless board certified by ABPN, AOA, or RCPS(C).
ABPN Sub-Specialty (Specify):	MM/YYYY    MM/DD/YYYY	<b>MEDICAL LICENSURE</b>
American Osteopathic Board of Neurology and Psychiatry:	MM/YYYY    MM/DD/YYYY	State and License Number (Required*)      Expiration Date: MM/DD/YYYY
Royal College of Physicians and Surgeons of Canada:	MM/YYYY    MM/DD/YYYY	*Not required if you are a psychiatrist in an academic, research, or government position not requiring a license.
Other (Specify):	MM/YYYY    MM/DD/YYYY	<input type="checkbox"/> Check here if license not required.

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## NATIONAL AND LOCAL MEMBERSHIP DUES

Members of the TSPP must also belong to the National Branch APA. DB will be assigned based on the member's preferred mailing address or current military service.

Applications for membership with APA can be found at <https://www.psychiatry.org/join-apa>

## 2022 - 2023 TSPP MEMBERSHIP DUES

\$50 – Resident-Fellow Members

\$410 – General Members

\$410 – Associate Members

\$410 – Fellows

\$410 – Distinguished Fellows

\$410 – Honorary Fellows

\$210 – Semi-Retired

\$136.67 – Retired

Select here if you prefer to make payment via payment link. You will receive a link from us to complete your payment and application processing. If you would like the link to be sent to a different email address than what you provided in your application, please include it here:

## PAYMENT INFORMATION

Check enclosed. Must make payable to Texas Society of Psychiatric Physicians and remit in U.S. funds drawn on a U.S. bank.

Amount to be Charged (USD):

\$

Credit Card: Visa MasterCard American Express

Credit Card Number:

Name As It Appears On Card:

Expiration Date: MM / YYYY

Security Code:

Signature

Date: MM / DD / YYYY

## AGREEMENT

In consideration of my membership in the APA and the District Branch, which I understand is a privilege and not a right, I agree that TSPP may make inquiries about me and that I am not entitled to the results, that I will pay the dues required on or before the due date, that I will adhere to the standards of ethical practice and conduct as well as the procedures outlined in the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, that TSPP may publish my membership data in its membership database to which all members and third parties permitted by TSPP will have access, that TSPP may provide government authorities all information pertaining to me if in receipt of a subpoena from authorities or if the institution seeking the information is a public institution which has paid all or any portion of my membership dues or CME fees, and that I will hold TSPP, the District Branch, and if applicable, the State Association harmless from any and all liability arising out of or relating to my membership, including but not limited to, decisions concerning membership, ethics, and/or the provision or storage of my personal and/or financial information. Any disputes that arise out of or relate to this agreement and/or my membership shall be governed by District of Columbia law without regard to its choice of law principles and any hearings or proceedings shall be heard in the District of Columbia. Upon review and acceptance of an application by the APA, you will be given provisional membership, and full APA benefits, while the District Branch (DB) reviews the application. Voting rights will not commence until you become a fully recognized member in the DB (including payment of dues) at which time you will be a fully recognized member of the APA and the DB. If a DB rejects an application, the reason will be provided along with a full refund of payment.

By checking this box, I understand that an electronic (typed) signature has the same legal effect and can be enforced in the same way as a written signature.

Signature:

Date: MM / DD / YYYY

