



5272 River Road, Suite 630 • Bethesda, MD 20816
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Application for Membership

CANDIDATE PLEASE NOTE:

Please fill out this form in its entirety using Microsoft Word. Enter the requested information in the areas that are gray. The text fields will expand as you type; click your mouse in a box to check or uncheck a box. Pressing the Tab key will advance the cursor to the next field; pressing Shift+Tab moves the cursor back one field.

Use the "Save As" command (in Word's File menu) to save this application to your hard drive. If you will be e-mailing the application to the Academy office, please give it a filename that identifies the file as a membership application and that includes at least your surname, for example: *mbr-app-JohnDoe.doc* or *apm-mbr-app-Smith.doc*.

Applications cannot be considered without your curriculum vitae (CV), payment, and a Sponsor Form that each sponsor you identify below completes and sends to the Academy.

- **CV:** You may e-mail your CV along with this application to apm@apm.org. If your CV is not in electronic form, mail a hardcopy to "APM – Application" at the address above with an accompanying explanatory note.
- **Payment:** If you pay by credit card, enter the card information at the end of this form. If you pay by check, mail your check (in U.S. funds) to "APM – Application" at the address above with an accompanying explanatory note.
- **Sponsor Forms:** A form for sponsors to fill out and submit is available at www.apm.org/join. Sponsor forms submitted to the Academy by the applicant are not acceptable.

TYPE OF MEMBERSHIP: (All membership categories include a subscription to the Academy's journal, *Psychosomatics*.)

Check the appropriate box:

- \$225.00 FULL MEMBER. Psychiatrist actively engaged in consultation-liaison psychiatry, medical psychiatry, and/or psychosomatic medicine.
- \$175.00 ASSOCIATE MEMBER. Individual with advanced degree in a related field and actively engaged in consultation-liaison psychiatry, medical psychiatry, and/or psychosomatic medicine.
- \$ 55.00 POSTGRADUATE FELLOW / RESIDENT / INTERN / STUDENT.

CANDIDATE INFORMATION:

NAME: First: _____ Middle: _____ Last: _____

Graduate Degree(s): _____

Preferred mailing address for APM mail:

Date of birth: Month: _____ Day: _____ Year: _____

Telephone (Home) _____

Telephone (Office) _____

Telephone (Cell) _____

Fax (Office) _____

Email _____

CURRENT PROFESSIONAL POSITION(S):

TITLE	INSTITUTION & CITY	DATES

STATEMENT OF CURRENT ACTIVITIES:

Please describe your current activities in consultation-liaison psychiatry/psychosomatic medicine:

SPONSORS: Either two APM members OR three non-members may act as sponsors. The candidate is responsible for ensuring each sponsor completes and submits to the Academy office a Sponsor Form (www.apm.org/join/APM-sponsor-form.pdf) regarding the sponsor's professional relationship to candidate, the candidate's professional practice, achievements, and ethics, and the candidate's standing in the local professional, academic, and civic community. It is essential that a current email address be entered for each sponsor.

Sponsor #1

Name: _____
 Street Address: _____
 City/State/Zip/Country: _____
 Phone: _____
 E-mail: _____
 APM Member? Yes No

Sponsor #2

Name: _____
 Street Address: _____
 City/State/Zip/Country: _____
 Phone: _____
 E-mail: _____
 APM Member? Yes No

Sponsor #3

Name: _____
 Street Address: _____
 City/State/Zip/Country: _____
 Phone: _____
 E-mail: _____
 APM Member? Yes No

BOARD CERTIFICATION(S): (or other, if applicable)

Name of Board: _____ Date: _____ Board Certified Exam taken, awaiting report
 Name of Board: _____ Date: _____ Board Certified Exam taken, awaiting report
 Name of Board: _____ Date: _____ Board Certified Exam taken, awaiting report

LICENSURE: Give jurisdiction and license number(s)

Have you ever been the subject of disciplinary action by any federal, state, or local professional licensing authority?

No Yes—please explain:

PAST PROFESSIONAL POSITIONS: Employment following graduate education, in chronological order. Additional information may be supplied on your curriculum vitae.

INSTITUTION & LOCATION	APPOINTMENTS OR POSITIONS	DATES

EDUCATION: Additional information may be supplied on your curriculum vitae.

	INSTITUTION & LOCATION	YEAR GRADUATED	DEGREE
Medical School			
Internship			
Residency			
Fellowship			
Other Graduate Education			
Postgraduate Education			

SIGNATURE OF CANDIDATE: By submitting this electronic document to the Academy of Psychosomatic Medicine, I understand that, in order to evaluate my proposal, the Academy will review my credentials. I agree to cooperate in such review and allow others to provide information regarding my credentials. To the best of my knowledge, all information furnished by me in this proposal is true and complete.

If paying by credit card, please provide the credit card information below. If paying by check, mail your check (in U.S. funds) to: APM – Application, 5272 River Road, Suite 630, Bethesda, MD 20816. Your check will not be cashed, nor your credit card debited, until you have been approved for membership.

If paying by credit card, please enter information here:				<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Amex
Card number: _____	Exp. Date (mo./year): _____	Security Code: _____				
Name on card: _____	Amount (in U.S. funds): \$ _____					