



AMERICAN COLLEGE OF OSTEOPATHIC PEDIATRICIANS

2209 Dickens Rd., Richmond, VA 23230-2005 • Phone: 804-565-6333 • Fax: 804-282-0090

E-mail: greg@acoped.org • www.acoped.org

MEMBERSHIP APPLICATION

First Name: _____ Last Name: _____ MI: _____

Male Female Preferred Contact Address: Mailing Billing

Mailing Address: _____ Billing Address: _____

City: _____ City: _____

State/Country: _____ Zip/Postal Code: _____ State/Country: _____ Zip/Postal Code: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

E-mail: _____ Address to be published in directory or web site? Mailing Billing Neither

Secondary E-mail: _____ AOA #: _____ AAP#: _____

Note: The ACOP does not provide member phone/email information to outside vendors. Please supply your email address to expedite important ACOP communications in a more timely and cost effective method.

DOCTORAL AND POSTDOCTORAL TRAINING

All applications are reviewed by the ACOP Membership Committee and Board of Trustees. Please allow 3-4 weeks for the approval process and to receive confirmation in writing. Please note: Failure to provide a completed membership application (including information below) may result in denial of membership in the ACOP.

Undergraduate Education: _____ Location: _____ Dates: _____

Graduate Education: _____ Location: _____ Dates: _____

Osteopathic Medical School _____ Location: _____ Dates: _____

Internship Institution: _____ Location: _____ Dates: _____

Residency/Fellowship Institution: _____ Location: _____ Dates: _____

Are you board eligible? Yes No Are you board certified? Yes AOBP ABP No

Academic Affiliation(s): _____

Hospital Staff Positions Currently Held: _____

Primary Institutions and Locations: _____

Specialty: Adolescent Medicine Allergy/Immunology Child Neurology Emergency Medicine Family Medicine Gastroenterology
 General Pediatrics Hospitalist Internal Medicine Med/Pediatrics Neonatology OMM - Peds & Adults Pediatric Endocrinology

If accepted for membership, I agree to abide by the Code of Ethics and the Constitution and Bylaws of ACOP. By Submission of this document, I authorize release of the information contained herein and in membership files of those organizations and hospitals to which I may subsequently apply for membership, and the release to ACOP by organizations and hospitals of information relative to my previous membership in those organizations. I am a resident or a licensed physician in compliance with the state board of medical licensure and/or discipline's order.

Signature: _____ Date: _____

MEMBERSHIP CRITERIA

Fellow

Licensed osteopathic physicians certified in pediatrics by the American Osteopathic Board of Pediatrics or the American Board of Pediatrics. Fellows may vote on all governance issues, hold elective office, and serve on all ACOP committees.

Associate

Licensed osteopathic physicians who have completed a pediatric training program acceptable to the ACOP Executive Council. Associate members may vote on all governance matters, hold elective office, and serve on all ACOP committees.

General

Licensed osteopathic physicians who have a personal interest in pediatrics. General members may not vote or hold elective office, but may serve on all ACOP committees.

Candidate

(Intern/Resident/Fellow-in Training)
Interns, Residents or Fellows-in-Training participating in an approved training program. Candidate members may not vote or hold elective office, but may serve on all ACOP Committees.

Student Membership: Students must complete the Student Membership Application.

All applicants will be reviewed by ACOP, and applicants will receive prompt notice when approved. The process takes approximately two months.

Fellow* \$400 Intern** \$20 End Date _____

Associate \$400 Resident** \$30 End Date _____

General \$400 Fellow-in-Training** \$30 End Date _____

***Please provide: Copy of state license and proof of board certification, if applicable.**

****For Interns, Residents and Fellows-in-Training: Note from program director indicating participation in a training program.**

Payment Options (Please do not send cash for payment)

Check or Money Order Enclosed (US Funds) Made Payable to: ACOP, 2209 Dickens Rd., Richmond, VA 23230-2005.

If paying by check, you MUST include a copy of this application with your payment.

AmEx Mastercard Visa Discover Card Number: _____

Printed Name on Card _____ Exp. Date _____

Billing Address _____ Zip Code _____

Signature _____ CVV Security Code* _____

*CVV code is the three digit number on the back of VISA or MC or 4 digit number on the front of AMEX card above the account number.