



APPLICATION FOR MEMBERSHIP PLEASE PRINT OR TYPE

1. Full name _____ First Middle Last

2. Please check category of membership:

- ___ AAP Fellow or Specialty Fellow—Colorado Chapter annual dues: \$120
___ AAP Candidate Fellow—Colorado Chapter annual dues: \$95
___ AAP Post-Residency Fellow—Colorado Chapter annual dues: No Colorado Chapter dues
___ AAP Resident Fellow—No Colorado Chapter dues
___ Colorado Chapter Affiliate Member*—Colorado Chapter dues: 100. *Complete Item 4.
___ Emeritus Member—No Colorado Chapter dues
___ Life Member—No Colorado Chapter dues

3. Directory of Members. Please make the listing exactly as you want it published.

Name _____ E-mail _____
Street _____ Phone _____
City _____ County _____ State _____ ZIP _____

Specialty _____ Bd. Cert. Bd. Elig.
Subspecialty _____ Bd. Cert. Bd. Elig.

Preferred mailing address if different than above:

Street _____
City _____ County _____ State _____ ZIP _____

4. Academic history (for Affiliate Members only):

Medical School _____ Grad. Year _____
Internship _____ Years _____
Residencies _____ Years _____
Postgraduate Work _____
Hospital Staff _____
Percentage of professional time devoted to pediatrics _____

5. Date _____ Signature _____

DUES CHECK MUST ACCOMPANY APPLICATION
PLEASE MAKE CHECK PAYABLE TO CCAAP AND RETURN TO
COLORADO CHAPTER, AAP, P.O. BOX 4834, ENGLEWOOD, CO 80155
PHONE: 303-770-6048 · FAX: 303-771-2550