



Massachusetts Chapter of the American Academy of Pediatrics Application for Membership

I am hereby applying for membership in the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP). I certify that I am a board certified pediatrician and am licensed by the Board of Registration in Medicine to practice in Massachusetts.

Name: _____ Date of Birth: _____

Business Address: _____

Business Telephone () _____ FAX () _____

Home Address: _____

Home Telephone () _____

Preferred Mailing Address: _____

e-mail address _____

Social Security Number _____

Male or Female _____

Medical Degree: _____ Year: _____ School: _____

Pediatric Residency Location: _____ Dates: _____

Fellowship Training Location: _____ Dates: _____

Are you a member of the American Academy of Pediatrics? Yes No

Are you a member of the Massachusetts Medical Society? Yes No

MA License Number: _____ Effective Date: _____

Type of Practice (solo, group, private, salaried): _____

Corporate Name (if applicable): _____

Principle Hospital Affiliations: _____

List the HMOs, PPOs, etc. to which you belong: _____

Is any part of your practice located in another state? If so, where?

Do a significant number of patients come to you from another state? If so, where?

What are the major issue(s) that you would like the Chapter to address?

Membership fee is \$135 for practicing pediatricians. Membership is free for residents-in-training or students. Please mail this application to: Cathleen Haggerty, MCAAP Box 9132, Waltham, MA 02454.

Signature _____ Date _____