

Medical Student Membership Application

Biographical Information

Last Name: _____ First Name: _____

Middle Initial: _____ Suffix: _____ Birth Date: MM/DD/YYYY Gender: _____

Mailing Address: _____

City: _____ Province/State: _____ Postal Code: _____

Telephone (with Area Code): _____ Email: _____ Are you active military? Yes No

Medical School Attending: _____

Mailing Address: _____

City: _____ Province/State: _____ Postal Code: _____

Country: _____ Date Entered Medical School: MM/YYYY Expected Date of Graduation: MM/YYYY

Please accept my application for Medical Student membership in the American Psychiatric Association. If my Medical School is based outside the United States or Canada, it will be an International Medical Student Membership. I understand that I am eligible for APA Medical Student or International Medical Student membership as long as I am enrolled in an accredited medical school. If, upon graduation, I have chosen to enter an approved psychiatric residency training program, I will then be eligible to apply for membership as an APA Resident-Fellow Member. My signature indicates that I agree to abide by the Bylaws of the APA; as well as the procedures outlined in the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, that APA may publish my membership data to its members, license or sell my name, address, phone number and/or e-mail to third parties, and provide government authorities all information pertaining to me if in receipt of a subpoena from authorities. I will hold APA 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 state of District of Columbia; and I pledge myself to the highest standards of ethical practice and conduct.

Signature _____ Date: _____



Join Today!

American Psychiatric Association
Membership Department

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Suite 900, Washington, DC 20024

Email:
membership@psych.org

Scan/Fax:
202-403-3673