



AMERICAN ACADEMY OF CLINICAL PSYCHIATRISTS

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Glastonbury, CT 06033 USA
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Fax: 860-633-6023 or 866-668-9858
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Website: www.aacp.com

Application for Membership

Your completed application must contain the following information:

1. Current Position & Contact Information
2. Letter from residency director for resident
3. Application Fee:
 - \$225 Active Member, 1 Year
 - \$400 Active Member, 2 Years
 - \$ 90 Affiliate Member
 - \$50 Student/Resident/Early career member

Name: _____ Degree: _____

Mailing Address: _____

City, State, Zip: _____

Country: _____

Phone: _____ Email: _____

If Resident: Residency Director Information

Name: _____

Address: _____

City/State/Zip: _____ Email: _____

AACP Member Yes No

I fully release the AACP staff or board to contact any above noted sponsor or Residency Director to provide information regarding my fitness for membership in AACP. Such information may include ethical conduct, academic/professional achievement, current practice and standing in the professional community. By signing this form I affirm that my medical license has never been sanctioned or is under current investigation and that I have never been convicted of any criminal offense.

Signature _____ Date _____