los angeles pediatric society

APPLICATION FOR MEMBERSHIP

Pediatricians as well as other physicians, surgeons, and licensed allied health professionals who have a particular interest and concern with the health and welfare of infants, children and adolescents are eligible to apply for membership. Members residing outside of California will be classified as affiliate members. Membership for all categories is $125 a year. Please complete each of the following items as applicable.
*Life membership is available at a one-time fee of $1,250.

PLEASE PRINT OR TYPE

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1. *Full Name* ______________________________ Birth Year _________
First *Middle* *Last*

Academy and College members are urged to add affiliation initials after degree.

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2. *Please indicate your mailing address (for LAPS admin use) and your preferred online physician locator listing address.*

Preferred Mailing Address ☐ **Office Location: yes** ☐ **no** ☐

1. ______________________________
Street *City* *State* *Zip*

Email ____________ *Phone*____________ *Fax*____________

Preferred Locator Address ☐ **(if different from above)** **Office Location: yes** ☐ **no** ☐ **Web Address**____________

2. ______________________________
Street *City* *State* *Zip*

Email ____________ *Phone*____________ *Fax*____________

(If you wish to list multiple addresses on the online locator, you may attach a list.)

A Physician Locator is available online at www.lapedsoc.org. Your practice address information will be included in the Physician Locator, unless you choose to opt out. **Do NOT include my practice in Physician Locator.** ☐

Specialty ____________ ☐ *Bd. Cert. Date of Cert.*_________ *Date of Re-Cert.*_________ ☐ *Bd. Eligible*

Subspecialty: ____________ ☐ *Bd. Cert. Date of Cert.*_________ *Date of Re-Cert.*_________ ☐ *Bd. Eligible*

Note Board name for Specialty ______________________________

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3. *Medical School* ______________________________ *Year Graduated* ____________

Internship ______________________________ *Years* ____________

Residencies ______________________________ *Years* ____________

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Other Professional Training ______________________________

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Hospital Staff ______________________________

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☐ *Private Practice: Total Years* ____________ ☐ *Academic Practice: Total Years* ____________

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4. *Member in good standing of other medical and scientific societies* ______________________________

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5. *References (Name of two physicians, preferably members)*

1. ____________________ *2.* ____________________

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6. ☐ **LIFE MEMBERSHIP*

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7. *Date* ____________________ *Signature:*____________________

YOUR CHECK FOR FIRST YEAR'S DUES ($125) MUST ACCOMPANY APPLICATION
***LIFE MEMBERSHIP: $1,250 (One-Time)**
Make checks payable to: los angeles pediatric society • P.O. Box 4198, Torrance CA 90510-4198

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