Texas Pediatric Society
The Texas Chapter of the American Academy of Pediatrics

RESIDENT / FELLOW (Please circle one)
MEMBERSHIP APPLICATION

[Please TYPE or PRINT CLEARLY all information requested]

TPS RESIDENT / FELLOW Membership Fee ONLY $15!

Name: _____ ❑MD ❑ DO
(First) (Last) (Middle)

Residency/Fellow Program: _____

Home Address: _____ City: _____ ZIP: _____

Preferred Phone: _____ (Please circle one): Home Cell

Alternate Phone: _____ (Please circle one): Home Cell

Preferred E-mail: _____ Alternate e-mail: _____

Date of Birth: _____ ❑Male ❑Female

Preferred Mailing Address: Office Home (Please circle one)

Preferred Billing Address: Office Home (Please circle one)

Education (List **INSTITUTIONS** and **DATES** attended)

Medical: _____ Grad Date: _____

** Pediatric Residency: _____ Est. Comp Date: _____

** Fellowship/Specialty: _____ Est. Comp Date: _____

Do you hold a Texas Medical License (if yes, please provide license number)?_____

_____ _____
Signature of Applicant Date

** Upon completion of your pediatric residency training, or fellowship, you must request elevation to Active Member status by contacting the Texas Pediatric Society in Austin.

☐Check (included)
☐VISA
☐MasterCard
☐Discover

Card #:_____ Exp. Date:_____ CID (3 digits on back of card):_____

Name as it appears on card: _____

Billing Address (if different from above):_____
Address City/ST ZIP

Please complete and return with payment to:
Texas Pediatric Society
Attn: Membership Department
401 W 15th Street, Ste 682
Austin, Texas 78701-1665
P: (512)370-1517