Association of Women Psychiatrists

P.O. Box 570218 • Dallas, Texas 75357-0218

ALEXANDRA SYMONDS, M.D.
FOUNDER: 1983

Membership Application Form

Name: ______________________________ Date: ______________

Address: ____

Phone/Office: ________________ Home: ______________________

Fax: ____________________ E-mail: _______________________

Medical school: ________________________ Year of graduation: __________

Psychiatric residency training: ________________________ Year completed (or to be completed): ________

Postgraduate education: ________________________ Year completed: __________

Areas of special interest in psychiatry: ____________________________

Board Certification in Psychiatry and Neurology Yes ____ No ____ Other Board Certification: ______________

APA Member Yes _____ No _____ AMWA Member Yes _____ No ____ AMA Member _ Yes _____ No ____

Member of APA Council/Committee or Other Yes______ No ______ Please Specify ________________

Have you put in a written request to APA President-elect for Committee/Council Appointment? Yes ______ No _____

If yes, which APA component would you like to serve on? ______________________

Which AWP Committee would you be interested in chairing or becoming a member of? ______________________

Signature: ________________________________ Date: __________

Annual Dues
General Member: $75.00
Part Time Member: $45.00
Retired Member: $ 45.00
Residents: $20.00 with copy of ID

International Member: $100.00
All dues include
NWP subscription AWP

Enclose your check payable to AWP, Inc.
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