Membership Application

Name:_____
First Middle Initial Last

Title:_____

Institution/Affiliation:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____ Email:_____

Academic Training:
Medical School:_____

City:_____ State:_____ / Country:_____ Zip Code:_____

Graduation Date: (___/___/_____) Degree:_____
mo day yr

Primary Specialty (choose one)
□ Psychiatry (adult) □ Psychiatry (child/adol) □ Psychology □ Pediatrician

□ Primary Care Physician □ Nurse Practitioner □ Physician Assistant □ Other_____

Please check membership category applying for
□ Full $175 □ International $150 □ Associate $150 □ Fellow/Resident $100

Method of Payment
Dues Amount: $_____ □ Payment enclosed (check made payable to APSARD)

Please charge my: □ Visa □ MasterCard □ American Express

Card Number:_____
Expiration Date:_____/_____/_____
Signature:_____
Date:_____
Please note your credit card statement will read "APSARD Membership"

Please return the completed application to:
American Professional Society of ADHD and Related Disorders
19 Mantua Road · Mt. Royal, NJ 08061
Phone (856) 423-8702 · Fax (856) 423-3420 · Email info@apsard.org
Join Online at www.apsard.org