**Application for Regular Membership**

**Please send application with membership fee to:**

**Austin Psychiatric Society**

**Attn: Charla Clark**

**PO Box 302586**

**Austin, TX 78703**

**Or e-mail to:** **austinpsychiatricsociety@yahoo.com**

\_\_\_First Year in Practice ($50)

\_\_\_Regular Member($150.00)

\_\_\_Resident in Training $50)

\_\_\_Retired($75)

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  |  |  |
| **contact e-mail:** |  |  |  |
| Business Address: |  |  |  |
| Business Phone: |  |  |  |
| Business Fax: |  |  |  |
| Business Website: |  |  |  |
| Contact Address (if different from above): |  |  |  |
| Contact Phone (if different from above): |  |  |  |
| APS member who referred you: |  |  |  |
| Education (Medical School, Residency, Fellowship, Other)  | Name | Degree | Graduation Year |
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| Texas Medical License number: |  |  |  |

Please check all of the areas which describe your current practice:

|  |  |  |
| --- | --- | --- |
| General Categories | Age Categories | Location |
| Mental Health | Geriatrics >65 | Inpatient |
| Substance Abuse | Adult 18-64 | Outpatient |
| Employee Assistance Program | Adolescent 13-17 | Mobile crisis |
| Other: | Child 0-12 | Other: |

Check all of the areas within your scope of practice for which you have training and expertise, and for which you are accepting referrals (Please choose top 3):

|  |  |
| --- | --- |
| Specialty | Specialty |
| Depressive Disorders | ECT |
| Anxiety Disorders | Forensic |
| Personality Disorders | Neuropsychological Testing |
| Cognitive Disorders | Psychological Testing |
| PTSD | Neuropsychiatric Assessment |
| Bipolar Disorders | Faith-based counseling |
| Psychotic Disorders | Worker's Comp/Disability |
| Eating Disorders | Life coaching |
| ADHD | Research |
| Conduct Disorders | Group Psychotherapy |
| Developmental Disorders | Psychodynamic Therapy |
| Sexual Disorders | Cognitive-Behavioral Therapy |
| Gay/Lesbian/Transgender Issues | Psychoanalysis |
| Perpetrators of Violence/Abuse | Supportive Therapy |
| Victims of Violence/Abuse | Marriage/Family Therapy |
| Medical Co-morbidity | Interpersonal Therapy |
| Chronic Pain | Other: |
| Medication management | Other: |

Are you currently accepting insurance? If so please list the insurance plans for which you are accepting new patients:

|  |  |
| --- | --- |
| 1.  | 2.  |
| 3.  | 4.  |
| 5.  | 6.  |
| 7.  | 8.  |

I would like my **business** information (Name, Address, Phone, Fax, and Website) to be listed in the APS directory for other APS members and the public to access

In addition, I would like the following additional information (e.g. e-mail address) to be listed in the APS directory for other APS members and the public to access (please fill in the blank):

I would not like to be listed in the APS directory