**Application for 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@gmail.com**

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

\_\_\_Regular Member($150.00)

\_\_\_Resident in Training ($50) \_\_\_Retired($75)

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| --- | --- |
| **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)  | NameDegreeGraduation Year |
| Texas Medical License number: |  |