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 _____

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

Awards_______ Bylaws _______ Membership _______ Program _______ Newsletter _________

Signature: ______________________________ Date: ____________

Annual Dues

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

Medical Student: Dues Wavied
International Member: $25.00
All dues include
NWP Subscription AWP

Enclose your check payable to AWP, Inc.

Please mail to:
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