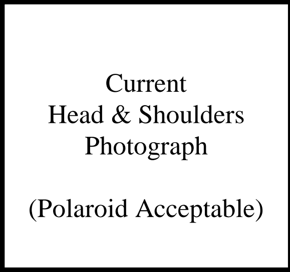
AMERICAN ACADEMY OF
DISABILITY EVALUATING PHYSICIANS (AADEP)
223 W Jackson Blvd, Suite 1104, Chicago, IL 60606-6900

APPLICATION FOR MEMBERSHIP (MEDICAL)



Name of Sponsor (if applicable): ______________________________, **FAADEP**

Signature of Sponsor : ___________________________, **FAADEP**

NAME: **Please leave one blank space between first, middle and last names.**	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Last Name First Name Middle Initial Degree: ☐☐ MD or DO
ADDRESS: **The preferred address will be used by this office for all mailings until you advise us of a change.** **Preferred Mailing Address:**	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Business Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Home Address ☐ Business ☐ Home
TELEPHONE/FAX / E-MAIL NUMBERS:	☐☐☐ ☐☐☐☐☐☐☐☐ ☐☐☐ ☐☐☐☐☐☐☐☐ Office Fax ☐☐☐ ☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Home E-Mail Address
DATE OF BIRTH AND SOCIAL SECURITY NUMBER:	☐☐ ☐☐ ☐☐ ☐☐☐ – ☐☐ – ☐☐☐☐ Month Day Year Social Security Number
TRAINING: **Please list**	MEDICAL SCHOOL (Location) ______________________________ Exact Date(s) ☐☐ ☐☐ ☐☐ TO ☐☐ ☐☐ ☐☐ Inclusive From Month Day Year Month Day Year
INTERNSHIP: **Please list**	INSTITUTION (Location) ______________________________ Exact Date(s) ☐☐ ☐☐ ☐☐ TO ☐☐ ☐☐ ☐☐ Inclusive From Month Day Year Month Day Year

RESIDENCY: **Please list**	INSTITUTION (Location) ______________________________ Exact Date(s) Inclusive From ☐☐ Month ☐☐ Day ☐☐ Year TO ☐☐ Month ☐☐ Day ☐☐ Year
POST GRADUATE TRAINING: **Please list all training** **BOARD ELIGIBLE** ☐ **BOARD CERTIFIED** ☐	INSTITUTION Specialty______________________ ______________________________ Exact Date(s) Inclusive From ☐☐ Month ☐☐ Day ☐☐ Year TO ☐☐ Month ☐☐ Day ☐☐ Year
AADEP REQUIRED COURSEWORK:	SHORT COURSE ☐☐ Month ☐☐ Year CLINICAL ☐☐ Month ☐☐ Year Are you applying for Fellowship? Yes_____ No_______ If so, please request Fellow Packet. (You must complete both courses within three years.)
CURRENT CV:	PLEASE PROVIDE A COPY OF CURRENT CURRICULUM VITAE
LICENSURE:	PLEASE SEND A COPY OF YOUR CURRENT STATE MEDICAL LICENSE
ACTIVITY IN DISABILITY MEDICINE:	How long has the evaluation of disability or impairment been a significant aspect of your professional activity? ______Years
Please indicate approximate percentage of time to these areas:	Breakdown of disability/impairment evaluations: Percent of practice dedicated to patient treatment _______% Percent of practice dedicated to disability/impairment evalautions _______% Independent Medical Evaluation _______% Social Security Disability Assessment _______% Worker's Compensation Assessment _______% Personal Injury _______% Other (Please specify) _______% (The above percentages should total 100%) Total _______%
RECOMMENDATIONS:	Provide two letters of recommendation from individuals familiar with your qualifications and standing in impairment evaluation.

PRINCIPAL STAFF MEMBERSHIP(S) (if any): Please list the name and address of the Administrator at the institution or agency where you hold your staff membership.	Medical Director or Administrator _____ Institution/Agency _____ Address _____ Exact dates of Membership _____ City _____ State _____ Zip Code _____ Medical Director or Administrator _____ Institution/Agency _____ Address _____ Exact dates of Membership _____ City _____ State _____ Zip Code _____
List Academic appointments and other professional organizations	Are you a member of the American Medical Association? ☐ Yes ☐ No Are you a member of the American Osteopathic Association? ☐ Yes ☐ No If yes, give AOA ID # ___________________________________ Other Professional Memberships/Academic Appointments: ___________________________________ ___________________________________ ___________________________________

(Include check in the amount of $50 payable to American Academy of Disability Evaluating Physicians)

APPLICATION STATEMENT: I hereby make application to the **American Academy of Disability Evaluating Physicians** for membership in accordance with and subject to the Board's rules and policies in effect from time to time, and enclose a non-refundable fee to cover the review of my credentials.

I agree that the Board shall be the sole judge of my credentials and qualifications for membership certification, I agree that the Board may disqualify me if the Board determines any information furnished by me is false, that I did not comply with or violated the Board's rules and policies.

I agree that my professional qualifications, including my moral and ethical standing in the medical profession and my competence in clinical skills, will be evaluated by the Board and that the Board may make inquiry of the persons named in my application and of other persons, such as authorities of licensing bodies, hospitals or other institutions as the Board may deem appropriate with respect to such matters; and I agree that the sources and all information furnished to the Board in connection with its inquiry shall be confidential, and not subject to disclosure, through legal process or otherwise, to me or to anyone acting on my behalf.

I hereby declare under penalty of perjury that the information given in the application is true and correct to the best of my knowledge and belief.

____

Signature (Name in Full) Date

Checklist: (Please verify enclosures below)

- Photograph
- CV
- Two letters of recommendation
- Copy of current state medical license
- Check ($50 Application fee)

For office use only (insert dates)

____ Receipt
____ Receipt of additional information
____ Membership Committee Approva l
____ Eligible for Fellowship