



"Interdisciplinary leadership for developmental-behavioral health"

For office use:
Check #: _____
Date Rec'd: _____
Amt: _____

SOCIETY FOR DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS
703-556-9222 * info@sdbp.org

2012 ASSOCIATE MEMBERSHIP APPLICATION

Name (please print): _____
Professional Degree(s): _____ DOB _____
Preferred Mailing Address: _____
Office Telephone and Fax #s: _____
E-Mail: _____
Institutional Affiliation: _____
Title of Developmental-Behavioral Training Program: _____
Expected Date of Program Completion: _____
PROGRAM DIRECTOR NAME
Title: _____
Address: _____
Email: _____ Tel #: _____

SDBP is committed to increasing the diversity of its membership and of developmental and behavioral pediatrics. To this end, we would like to get a profile of our members' racial and ethnic backgrounds and heritages. Although it is not mandatory to answer the following question, we would appreciate your response. This information will be kept confidential. Thank you.

How would you describe your race/ethnicity? (Please check all that apply) ___ Prefer Not To Answer

- ___ European American/Caucasian
___ European/Spain
___ African American
___ Native American/Alaskan Native
___ Indian/Indian Subcontinent
___ West Indian/Caribbean
Hispanic/Latino (please choose from the following):
___ Mexican American
___ Dominican
___ Other (describe)
___ Puerto Rican
___ Other Central/South American
___ Hawaiian/Pacific islander
___ East/Southeast Asian
___ Middle Eastern

Return application, supporting materials and Payment of \$110 to:

SDBP
6728 Old McLean Village Drive
McLean, VA 22101
Fax: 703-556-8729

We accept payment via Check (payable to SDBP), MasterCard or Visa.

If paying by MasterCard or Visa, please complete below:

Credit Card #: _____ Exp: _____
Signature: _____

Please enclose your curriculum vitae or resume. Letters of Reference can be mailed, emailed or faxed.

If you have any questions, feel free to call 703-556-9222 and ask for SDBP Membership.