

AMERICAN PSYCHIATRIC ASSOCIATION
REQUEST FOR DUES RELIEF

INTERNATIONAL MEMBERS AND FELLOWS

The APA Board of Trustees confers all forms of dues relief, upon recommendation of the APA Membership Committee. Upon receipt of this form, the APA will forward your request to the Membership Committee. **Dues Relief requests are strictly limited to two consecutive years unless extenuating circumstances exist.** International Members and Fellows who petition for relief must provide supporting documentation as feasible.

Member Name APA ID#

Mailing Address

City Province/State/County Country CEP/Postal Code

Phone Fax Email

I am requesting dues relief as specified below for the year(s)_____:

I am applying for a dues reduction in the following category (please check all that apply below):

_____ **Child-related:** New mothers, mothers-to-be (within six months) or fathers assuming primary parental responsibility with child-related reduced income-generating workloads are eligible for a 50% reduction of dues for one year. In the event that there are documented serious physical or psychological problems, there may be a full waiver of dues for one year. An individual may request further relief for one more year. **Provide details on page two of this form in the allotted space.**

_____ **Illness:** International Members/Fellows with an illness, who have been unable to work full-time for at least three months, are eligible for a reduction or waiver for a one year period as follows **(please check appropriate category below and provide details on page two of this form in the allotted space).**

- Able to work part-time, more than 20 hours/week 20% reduction _____
- Able to work part-time, less than 20 hours/week 50% reduction _____
- Unable to work at all 100% reduction _____

_____ **Financial Hardship:** International Members/Fellows facing financial hardship due to divorce, alimony, child support, college expenses for children, other family support obligations, repayment of student loans, change of career path or other special fiscal consideration are eligible for a one year reduction of dues of either 30% or 50%. Psychiatrists living in economically disadvantaged countries earning minimal salaries will be charged dues at the rate of one percent (1%) of his/her monthly salary with a \$5 per year minimum rate. **Please provide details on page two of this form in the allotted space.**

_____ **Retirement:** International Members/Fellows living in countries with a mandatory retirement age and **fully retired** (i.e. can not be earning any income from the profession, including consulting work) are eligible for a 50% reduction of dues based on the mandatory retirement age. Members must apply by contacting the APA in writing or submitting a Retired Dues Request Form for International Members/Fellows. Members receiving the Retired Dues reduction will continue to receive all benefits.

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Inactive Status: I understand that Inactive Status is a separate membership category that carries with it a change in benefits received. I am applying for Inactive Status as follows (please check the appropriate category below):

_____ **Temporary Inactive Status (Dues-exempt and limited to one year and available only January-June of the current year):** I am applying for Temporary Inactive status because I am **temporarily** unable to meet financial obligations and do not qualify for categories of dues reductions or waivers described above. I understand that Temporary Inactive International Members/Fellows do not receive online publications of the Association except by subscription. **Please provide details below.**

_____ **Permanent Inactive Status (Dues-exempt):** I am applying for Permanent Inactive status, because I am unable to continue as an active member of the APA as a result of a major illness or similar hardship. I understand that Permanent Inactive International Members/Fellows do not receive the online publications of the Association except by subscription. **Please provide details below.**

Details are provided below: (Please state the conditions of your financial hardship and provide relevant information such as number of hours working per week or monthly salary.)

Member Signature

Date

FAX THE COMPLETED FORM TO:

01-703-907-1085

MAIL THE COMPLETED FORM TO:

AMERICAN PSYCHIATRIC ASSOCIATION
MEMBERSHIP DEPARTMENT
1000 WILSON BOULEVARD, SUITE 1825
ARLINGTON, VA 22209-3901 USA

For APA Use Only:

Date to Membership Committee: _____

Date to Board of Trustees: _____

Approved: _____

Denied: _____