



Dear Member Applicant:

We are pleased to hear of your interest in applying for membership to the Pediatric Orthopaedic Practitioners Society (POPS). The mission of the society is to advance and enhance the care provided by the Advanced Practice Nurse and Physician Assistant specializing in Pediatric Orthopaedics. By bringing members together we aim to support continuing education, specialized training, research collaboration, mentoring, networking and promotion of our role.

Attached you will find an application form, a recommendation form, a By-Law compliance agreement form and an application checklist. The original and three copies of the completed application along with three copies of your curriculum vitae, state(s) of licensure (both active and non-active), and certification(s) (if applicable) should be sent to the POPS office along with the initial membership fee of \$250.00. Subsequent yearly dues are estimated to be \$150.00.

Upon receipt of your completed application form (including all items mentioned above), the two membership recommendation forms with letters of recommendation and application/membership fee, the completed application will be forwarded to the POPS Membership Committee for review. Following this process a recommendation will be submitted to the POPS Founding Board for final approval. If your membership is approved you will be notified by mail.

Thank you for your interest in our Society and we look forward to receiving you completed application.

**The Membership Committee,
Pediatric Orthopaedic Practitioners Society**



APPLICATION FOR MEMBERSHIP

(PLEASE TYPE OR PRINT CLEARLY)

Applicants must be in continuous practice for at least one year at the same location prior to applying for membership. A complete application includes copies of 1) your curriculum vitae with relevant educational degrees listed, 2) state(s) licensure (both active and non-active), 3) certifications (if applicable), 4) name/contact information for persons providing recommendations, and 5) signed By-Law Compliance agreement. Two completed membership recommendation forms with letters of recommendation are to be mailed directly from the person making the recommendation to POPS.

Name: _____

Nurse Practitioner ___ Physicians Assistant ___ Clinical Nurse
Specialist ___

Gender: ___ Female ___ Male Year of Birth _____

Ethnicity: ___ American Indian ___ Asian or ___ Black,
Not of
or Alaskan Native Pacific Islander Hispanic Origin
___ Hispanic ___ White, Not of ___ Other or
Hispanic Origin Unknown

Preferred Mailing Address: ___ Home ___ Work

Street _____

City State Zip Code _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

E-mail: _____ Fax: (____) _____ - _____

POPS policy allows release of member's mailing and email addresses to other POPS members and others as needed for educational, research and recruitment purposes. Phone & fax information is for internal use only by POPS staff and elected officials for

member communications. ___ Check here if you **do not** want your mailing or email addresses released for these purposes.

Years in practice as an NP / PA / or CNS: _____

Years in practice specializing in pediatric orthopaedics: _____

Date you began present position: ___/___/___

Please list the name & location of the practice you work in:

Total Practice Hours/Week: _____

Currently what percentage of your total clinical practice involves pediatric orthopaedics? _____% (A minimum of 75% is required for POPS membership)

Specialty:

___ Spine ___ Trauma ___ Sports Medicine
___ Hand ___ General Pedi Ortho ___ Other: _____

Have you ever had any professional license revoked or restricted in any way?

(If YES, please explain on a separate sheet)

YES ___ NO ___

Have you ever had any professional liability claims or suits filed against you?

(If YES, please explain on a separate sheet)

YES ___ NO ___

Have you ever been denied, removed, suspended or been involved with any disciplinary proceedings or had action taken against you within any professional association, society or place of employment?

(If YES, please explain on a separate sheet)

YES ___ NO ___

Have you ever been convicted of a crime?

(If YES, please explain on a separate sheet)

YES ___ NO ___

Any additional comments for membership consideration:

Name and Address of Persons Providing Letters of Recommendation

As applicant, you should provide both your recommending sponsors with the enclosed Membership Recommendation Form (*an addressed, stamped envelope provided by you is suggested as it will facilitate timely submission*). They need to complete the form and **return it directly to the POPS office** along with their letter of recommendation. Please note that letters of recommendation are to be completed only by fellow healthcare providers who can attest to the applicants' skill, practice, and character.

1. Name: _____

Address: _____

Phone: () - _____ Fax: () - _____

1. Name: _____

Address: _____

Phone: () - _____ Fax: () - _____

Pediatric Orthopaedic Practitioners Society (POPS)

c/o Children's Medical Center Dallas
Att: Debra Nugen, Dept. of Orthopaedics (E2.01)
1935 Medical District Drive
Dallas, Texas 75235

MEMBERSHIP RECOMMENDATION FORM

SPONSORS NAME & CREDENTIALS: _____

APPLICANTS NAME: _____

The above named applicant has applied for membership in the Pediatric Orthopaedic Practitioners Society (POPS), and has named you for a formal referral. Please complete this form and return it to the POPS office along with your letter of recommendation.

1. In what capacity (Program Director, Pediatric Physician, Colleague) and for how long _____ have you known the applicant?

2. Do you have first hand knowledge of the applicants practice profile?

3. Based on your familiarity with the above named applicant, is it your impression that _____
75% of their practice consists of pediatric orthopaedics?

5. A formal letter of recommendation must be attached to this form. In this letter please specifically address the applicants clinical judgment, knowledge base, professional competence, ability to relate to colleagues and patients and their moral and ethical values.

If you are unable to comment in depth on the applicant or cannot verify the applicants practice profile, please indicate this, and return the form to the Membership Committee at the POPS office at the above address.

SIGNATURE: _____ DATE: ____/____/____

**Compliance with By-Laws and Agreement of Confidentiality
Regarding Application**

The undersigned agrees that he/she will comply with each and every provision of the by-laws of the Pediatric Orthopaedic Practitioners Society and any duly adopted rules and regulations pursuant thereto.

It is specifically agreed by the undersigned that in consideration of the Pediatric Orthopaedic Practitioners Society treatment of the entire contents of this application, as well as inquiries or investigations made pursuant thereto as privileged and confidential material, and not subject to publication or public dissemination whether voluntary, involuntary, or operation of law; that the undersigned specifically authorizes the Pediatric Orthopaedic Practitioners Society to make whatever inquiries or investigations it deems necessary to verify the credentials, professional standing, and moral and/or ethical character of the undersigned. The undersigned agrees further that he/she will not cause or attempt to cause any public disclosure of the contents of any application for membership in the Pediatric Orthopaedic Practitioners Society or any proceedings of the Membership Committee or the Founding Board pursuant thereto whether said public disclosure be by operation of law or otherwise.

Signature: _____

Date: _____



APPLICATION CHECKLIST

- _____ An original and three copies of the completed and signed POPS membership application, including copies of requested documentation:
- _____ A current Curriculum Vitae
 - _____ State (s) licenses (both active and non-active)
 - _____ Certification (s) (if applicable)
- _____ Head shot photo for the membership directory, passport style
- _____ Initial Membership fee
(Please make check payable to Pediatric Orthopaedic Practitioners Society)
- _____ Active Member - \$250
 - _____ Candidate Member - \$200
 - _____ Associate Member - \$150
 - _____ Corresponding Member - \$150
- _____ I have contacted and requested that two appropriate persons complete a Membership Recommendation Form and letter of recommendation on my behalf, to be forwarded directly to POPS.

All completed applications should be forwarded to

Pediatric Orthopaedic Practitioners Society (POPS)
c/o Children's Medical Center Dallas
Debra Nugen, Dept. of Orthopaedics (E2.01)
1935 Medical District Drive
Dallas, TX 75235