



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 copy of the completed application along with copy 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 your completed application.

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



APPLICATION CHECKLIST

- _____ An original and qpg cop{ 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 ""
*****Dept. of Orthopaedics (E2.01)
1935 Medical District Drive
Dallas, TX 75235

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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: ____ / ____ / ____