Membership Application

AMERICAN COLLEGE OF CORRECTIONAL PHYSICIANS

O Begin O Renew My ACCP Membership

Your name should be submitted as you want it to appear on official correspondence. Please print.

First Name _____ Middle Initial ____

Last Name _____

Degree(s)_____

JobTitle _____

Place of Work _____

Mailing Address _____

City _____ State ___ Zip _____

Other Address _____

City _____ State ___ Zip _____

Phone _____ Fax _____

Mobile_____ Other _____

Email_____

Professional Training

O Physician O Psychiatrist

O Physician Assistant O Nurse Practitioner

O Dentist

O In Training (Student/Resident/Fellow)

If applicable are you Board certified? O Yes O No
If yes, specialty_____

Please Choose Membership Level

Physician:

O $150 (1 yr) O $265 (2 yrs) O $400 (3 yrs)

Physician Assistant, Nurse Practitioners, and Dentists:

O $100 (1 yr) O $190 (2 yrs) O $285 (3 yrs)

In Training (Student/Resident/Fellow):

O FREE

Verification of Eligibility

1. Do you currently have an unrestricted license to practice?
   O Yes O No (If no, please provide details separately)

2. Has your license ever been suspended or revoked?
   O Yes O No (If yes, please provide details separately)

3. Have you ever been convicted of a felony offense?
   O Yes O No (If yes, please provide details separately)

4. What graduate school did you attend?
   _____Year of Graduation_____

5. Are you an AMA member?
   O Yes O No

Application Statement

I am applying for membership in the American College of Correctional Physicians. By my signature, I attest that I am either a doctor of medicine, osteopathy, or dentistry who holds a license to practice medicine by an appropriate board of licensure that does not limit my practice solely to the correctional setting, or I am a Physician Assistant, Nurse Practitioner, student, resident, or fellow interested in the practice, teaching or research of correctional medicine. I certify that my application as submitted is true and correct. I agree to comply with ACCP's bylaws and code of ethics.

_____

Signature Date

Payment Information

O Paid Onsite via Credit Card

O Enclosed a check, payable to ACCP

Please bill my:

O MasterCard O Visa O American Express O Discover

Card Number _____
Expiration Date _____ Security Code _____
Billing Address _____
City_____State _____Zip_____
Signature_____

Return this registration form, along with payment, to:

American College of Correctional Physicians, 1145 W. Diversey Pkwy., Chicago IL 60614

Phone: (800) 229-7380 · Fax: (773) 880-2424