

Application for Affiliate Membership

Please type or print. This application must be accompanied by the below payment form and dues payment. See further instructions on reverse.

AAPA #: _____ (required) Applicant must be a Fellow Member of the American Academy of Physician Assistants (AAPA) to be eligible for ACP Affiliate membership.

Last Name _____ First _____ MI _____

Degree (i.e., "PA") _____

Preferred Mailing Address (for ACP mail) Street and Number _____

City _____ State _____ Zip/Postal _____

Mailing Address: Home Office Please check here if you wish to be excluded from non-ACP-related mailings.

Day Phone: () Day Fax: () E-mail address: _____

To assist in verifying information, please provide any other surname that you use or have used professionally: _____ Date of birth: ____/____/____ Gender: Male Female (Optional) Elect not to specify

Federal Service: Current Military Rank: _____ US Air Force US Army US Navy

Applicant's ACP #: _____ (if known, and already ACP customer) Priority Code (if known)

If you are currently employed by a member of the ACP, please indicate name and ACP number (if known):	
_____	_____
ACP Member Name	ACP #

I understand that in order to evaluate my application, ACP will review my credentials. I agree to cooperate in such review and allow others to provide information regarding my credentials. To the best of my knowledge, all information furnished by me in this application is true and complete.

Signature of Applicant _____ Today's Date _____
(Required)

ACP ONLY:
DNS Status _____ ACP Region Override: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> M
AAPA Fellow _____

(Do Not Detach)

AFFILIATE MEMBER DUES PAYMENT FORM

Marketing Code: ASAM89

Name: _____

Applicants for Affiliate membership must include a dues payment with their application form. Applications received without the dues payment will not be processed. Membership benefits begin once dues have been paid.

Payment Options: \$200* or \$ _____ pro-rated amount*

A check payable to ACP is enclosed. (Must remit in U.S. funds drawn on a U.S. bank.)

*Affiliate members are charged an annual dues rate of \$200 per fiscal year (ACP is on a fiscal year extending from July 1 through June 30). Annual dues are prorated on a monthly basis. You have the option of paying a full year's dues (\$200) or paying a prorated dues amount based on the month you are applying. For information on prorated dues amounts, please contact the Membership Coordinator at 800-523-1546, ext. 2704, or visit our website at www.acponline.org/dues.

Please charge my credit card: \$ _____ (Amount paid)

VISA MasterCard American Express Discover

Credit Card # _____ Security Code _____

Exp. Date _____ Signature: _____

If the amount paid differs from the actual dues amount owed, you will be billed/credited as appropriate.

Office use only: ACP number: _____

INSTRUCTIONS

1. Eligibility

Applicants must be current Fellow Members of the American Academy of Physician Assistants (AAPA) to be eligible for Affiliate membership in ACP. If status in the AAPA cannot be verified, the Affiliate membership will be cancelled.

2. Submission

Application Form. All information must be completed, and the application form must be signed by the candidate. Incomplete or unsigned applications will be returned to the applicant and will delay processing. The applicant should retain a copy for his/her records.

Dues Payment. The dues payment form must be submitted with the application. A check payable to the American College of Physicians, in U.S. funds drawn on a U.S. bank, should be included if applicant is paying by check. The dues payment can either be for an entire year (\$200 for July 1 through June 30) or can be a prorated amount based on the month you are applying. For information on prorated dues amounts, please contact the Membership Coordinator, or visit our website at www.acponline.org/dues. If the amount paid differs from the actual dues owed, the applicant will be billed/credited as appropriate.

The above materials should be sent to:

**Member Credentialing
American College of Physicians
190 N. Independence Mall West
Philadelphia, PA 19106-1572**

Generally, the election process takes approximately two weeks for complete applications that are accompanied by dues payment. Incomplete applications will not be processed. Applications that fail to meet the requirements within one year of the submission date shall be withdrawn.

3. Notification of Election

Applicants will be sent a welcome mailing within six weeks of election and can take advantage of membership benefits once the dues payment is applied. An ACP identification card will be included in the mailing.

4. Questions

For questions about qualifications and procedures, e-mail us at mbrservices@acponline.org, or call Member Credentialing at 215-351-2704; or toll-free in the United States or Canada, 800-523-1546, extension 2704 (M-F, 9 a.m.-5 p.m. ET).