

Please complete all fields and sign application below. This form is intended for physicians who are former Members, FACP or MACPs* of the College. If you have never been a Member, FACP or MACP* of the College, or if you were a member while a resident or student, please visit www.acponline.org/join to complete a membership application.

*MACP: Recipient of Mastership.

Applicant Contact Information

Last _____ First _____ MI _____

Company Name (if applicable) _____

Dept. _____ Suite _____ Apt. _____ Post Office Box _____ Private Mailbox _____

Street Address _____

City _____ State _____ ZIP +4 _____

Country _____ Mailing Address: Home Office

Please check here if you wish to be excluded from non-ACP-related mailings.

Current Military Rank (if applicable): _____

I wish to be part of the following U.S. Armed Forces ACP Chapter:

U.S. Army U.S. Air Force U.S. Navy

Demographic Information

Do you identify as Latinx, Latino, Latina or Hispanic?

Yes No Prefer not to answer

Do you identify as Middle Eastern or North African?

Yes No Prefer not to answer

With what racial group(s) do you identify? Please select all that apply.

Amer Indian, Native Amer, Indigenous or AK Native

Asian, Asian American or Pan Asian

Black, African American or Afro-Caribbean

Native Hawaiian or Pacific Islander

White

Prefer to specify: _____

Prefer not to answer

What is your gender?

Woman Man Genderqueer

Non-Binary/Third Gender

Prefer to self-describe: _____

Prefer not to answer

Do you identify as Transgender?

Yes No Prefer not to answer

Applicant's ACP # (if known)

Code: _____

Date of Birth
Month Day Year

Daytime Phone (required) _____

Cell Phone (required) _____

Preferred E-mail Address

(Required for immediate access to online member benefits, including journals)

Recovery E-mail Address

(For account authorization and deliverability purposes.)

National Provider Identifier (NPI): _____

(Provide your individual 10-digit NPI number)

Other surname used professionally _____

(To assist in verifying information)

SIGNATURE OF APPLICANT: I affirm that I have not been the subject of disciplinary action and that if I am in clinical practice that all medical licenses granted to me are active and current. I have read the ACP Pledge (www.acponline.org/acpledge) and affirm that I will uphold the ethics of medicine, as exemplified by the standards and traditions of the College.**

****If you are in clinical practice and your medical license(s) is (are) not in good standing, or if you have been subject to disciplinary action, please attach a detailed explanation, including current status, of any issue(s).**

Sign Here

Signature of Applicant (Required) _____

Date _____

Membership in ACP includes membership in ACP, your local ACP chapter, and ACP Services. A portion of your dues supports each entity. Members may not opt out of any of these entities.

- The majority of your membership dues may be tax deductible as a business expense. Dues are based on your member class and years since medical school graduation (if applicable). Your dues are allocated to several specific entities: primarily to ACP, secondarily to your local chapter (where applicable), and tertiarily to ACP Services. Full payment of dues is required in order to maintain ACP membership in good standing. Total dues owed are subject to change annually. Please note:
- ACP is a 501(c)(3) organization. The majority of your total dues allocated is earmarked for education, information, and publications, all of which support the College's mission. In addition, a subscription price for members who receive ACP print publications is a component of your national dues. Subscriptions cannot be deducted from dues.
- ACP Services is a 501(c)(6) organization. The smaller portion of your total dues allocated belong to ACP Services. These are earmarked for lobbying and advocacy as well as other business and noncharitable functions and are not deductible as a charitable contribution for U.S. federal income tax purposes. For information on the activities that fall within ACP Services, please visit www.acpservices.org.
- If you reside in an area where there is an ACP chapter, or if you are a member of the military, a portion of your dues is allocated to your local or military chapter.
- Members living outside of the United States pay discounted dues and may choose to receive online-only access to ACP publications. For information on dues rates for international members, please visit www.acponline.org/dues.
- ACP members are offered the exclusive benefit of access to "Member Connection." This is an online directory of ACP members (unless they ask not to be included) that is accessible to members only.

Please visit www.acponline.org/dues to learn how dues are apportioned to each entity. Consult your tax professional for more detail.

PLEASE DO NOT DETACH.

Please choose Membership option:

DUES RATES (July 1, 2024–June 30, 2025)	
8 years or less out of medical school	\$374
9 years or more out of medical school	\$570

PAYMENT REQUIRED FOR REINSTATEMENT

Amount Paid _____

ACP USE ONLY

Check enclosed. Must make payable to ACP, and remit in U.S. funds drawn on a U.S. bank.

Charge dues to:



Card # _____

Exp. Date _____ / _____ Security Code _____

Signature _____

Required

Full Name of Applicant (Please Print) _____

To reinstate membership:

Complete and sign this form and mail to:
American College of Physicians, Member Credentialing
190 N. Independence Mall West, Philadelphia, PA, 19106-1572, USA
Phone: 800-227-1915
Fax: +1-215-351-2799