

To apply for membership:

- 1. Please complete all fields and sign application below. All fields are required unless otherwise noted.**
- 2. Enclose your dues payable to: ACP (or include credit card information on the application) and return by fax or mail.**

Applicant Contact Information

Last _____ First _____ MI _____

Company Name (if applicable) _____

Dept. Suite Apt. Post Office Box Private Mailbox _____

Street Address _____

City _____ State/Province _____ ZIP/Postal Code _____

Country _____ Mailing Address: Home Office

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

Other surname used professionally _____
(If applicable; to assist in verifying information)

Type of License:

- Clinical Nurse Specialist Clinical Psychologist
- Clinical Pharmacist Licensed Practical Nurse

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 _____

Cell Phone _____

Preferred E-mail Address _____
(Required for immediate access to online member benefit, including journals)

Recovery E-mail Address _____
(For account authorization and deliverability purposes.)

License State _____

License Number _____

Expiration Date _____

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 licenses granted to me are active and current*. I have read the ACP Pledge (www.acponline.org/acppledge) 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 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).**



Signature of Applicant (Required) _____ Date _____

PLEASE DO NOT DETACH.

PAYMENT REQUIRED WITH APPLICATION

Send application with payment to: American College of Physicians, Member and Product Support, 190 N. Independence Mall West, Philadelphia, PA 19106-1572, USA, or fax to +1-215-351-2799.

Dues are for online-only benefits and are currently \$145 USD per year. ACP membership is valid for one year from join date.

Amount Paid: \$145 USD

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)

Instructions

1. Eligibility

Eligibility for ACP Non-Physician Affiliate membership shall include licensed non-physician health care professionals working in Canada who maintain a professional credential to practice. Non-Physician Affiliate membership is available but not limited to physician assistants; nurse practitioners and other advanced practice nurses, registered nurses, pharmacists and doctors of pharmacy, genetic counselors, clinical social workers, and clinical psychologists.

2. Submission of Application Materials

Generally, the election process takes approximately two weeks providing the application is complete and includes a dues payment.

- **Application Form.** All information must be completed, and the applicant must sign the application form. Incomplete or unsigned applications will be returned to the applicant. The applicant should retain a copy for their records.
- **Dues Payment.** ACP membership is valid for one year from join date.
All ACP dues are subject to change annually. Chapter dues are waived for newly elected members. Annual dues include fees to support both the national ACP and your local chapter.

3. Notification of Election

Applicants are sent a welcome e-mail within four weeks of election.

For Assistance, Call 800-227-1915 or +1-215-351-2600

(M-F, 9 a.m.-5 p.m. ET)

E-mail: help@acponline.org

Send Application and Dues Payment to:

ACP, Member and Product Support, 190 N. Independence Mall West, Philadelphia, PA 19106-1572 USA