

To apply for membership:

1. Complete and sign application below.

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
(To assist in verifying information)

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)

License State

License Number

Expiration Date

Type of License:

Clinical Nurse Specialist
Clinical Pharmacist
Clinical Psychologist

Licensed Practical Nurse
Nurse Practitioner
Physician Assistant

Registered Nurse
Other (please identify)

SIGNATURE OF APPLICANT: I affirm that all licenses granted to me are in good standing and that I have not been the subject of disciplinary action. I agree that my professional conduct will be consistent with the ethical standards of ACP and of my profession. I understand that ACP may review my credentials in order to evaluate my application.

If you are unable to check the box above, please contact ACP Member Credentialing directly at help@acponline.org, or call toll-free 1 800-227-1915.

Sign Here

Signature of Applicant **(Required)**

Date

Applicant Please Note: The following information will help provide ACP with accurate membership statistical data but will not be considered in connection with your application for membership. Completion is optional.

Gender: Male Female Elect not to specify

PLEASE DO NOT DETACH.

PAYMENT REQUIRED WITH APPLICATION

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

Dues are for online-only benefits and are currently \$119 USD per year (July 1, 2020 to June 30, 2021).

Amount Paid: \$119 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 nonphysician health care professionals 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 his/her records.
- **Dues Payment.** ACP's membership year runs from July 1 through June 30 of each year.
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

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

E-mail: help@acponline.org

Send Application and Dues Payment to:

ACP, Member Credentialing, 190 N. Independence Mall West, Philadelphia, PA 19106-1572 USA