ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

International Membership and Fellowship **REINSTATEMENT** Application

AS1117-17

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

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
Month Day Year

Daytime Phone

Cell Phone

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

National Provider Identifier (NPI):
(Provide your individual 10-digit NPI number. For US trained physician applicants only.)

SIGNATURE OF APPLICANT: I affirm that all medical licenses granted to me are in good standing and that I have not been the subject of disciplinary action.* I understand that, in order to evaluate my request for reinstatement, ACP will review my credentials. I agree to cooperate in such a review and allow others to provide information regarding my credentials. To the best of my knowledge, all information furnished by me in this request and in any supporting documentation is true and complete. I have read the ACP Pledge (www.acponline.org/memberpledge) and affirm that I will uphold the ethics of medicine as exemplified by the standards and traditions of the College.

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

Sign Here

Signature of Applicant **(Required)** Date

PLEASE DO NOT DETACH.

Please choose Membership option:

☐ Full Membership with print publications: $340 USD
☐ Online-only Full Membership without print publications: $260/$165/$115 USD
(Please visit **www.acponline.org/internationaldues** for specific dues rates by country.)
All dues quoted are for the membership year July 1, 2022–June 30, 2023.

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 +1-215-351-2799.

Full Name of Applicant (Please Print)

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:**

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Card #

Exp. Date Month Year Security Code

Signature
Required

For questions about requirements and procedures, e-mail ACP at help@acponline.org or call Member Credentialing at +1-215-351-2600 or toll-free in the U.S. or Canada at +1-800-227-1915 (M–F, 9 a.m.–5 p.m. ET).

Reset Form