

## PERSONAL DATA

I am applying as a: ☐ CV Veterinarian ☐ Geriatrician

Birth Date (Month/Day/Year) \_\_\_\_\_ Gender ☐ M ☐ F NPI # \_\_\_\_\_

Prefix	First Name	Middle Initial	Last Name	Suffix
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### Race/Ethnicity

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander  
☐ Asian ☐ Hispanic or Latino ☐ White ☐ Other \_\_\_\_\_

**Preferred Mailing Address** ☐ Work ☐ Home

### Work Address

Practice/Institution	Dept. Name	Company URL		
Hospital/Institution Address	City	State/Province	Postal Code	Country
Phone	Alternate Phone	Fax		

### Home Address

Home/Personal Address	City	State/Province	Postal Code	Country
Phone	Alternate Phone	Fax		

**Email Address** Check preferred email address ☐ Business ☐ Personal

Business Email	Personal Email
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## PAYMENT PAYMENT MUST BE INCLUDED WITH APPLICATION

**Please include a payment of \$125 with your application.** (\$100 annual dues plus a \$25 application fee)

☐ MasterCard ☐ VISA ☐ American Express ☐ Discover *ACC does not accept any other credit cards*

Card # \_\_\_\_\_ CSC # \_\_\_\_\_ Exp. Date \_\_\_\_\_ Total Amount \_\_\_\_\_  
 (3-digit number on back of card or front of Amex)

☐ Check – payable in US funds drawn on a US bank. Check # \_\_\_\_\_ Amount \_\_\_\_\_

## SPONSORSHIP

Applicants must submit two sponsorship letters from current Fellows of the ACC.

☐ I have attached two sponsorship letters from current FACC members

Sponsor #1 Name (FACC)

Sponsor #2 Name (FACC)

## LICENSURE

Are you currently licensed to practice medicine? ☐ Yes ☐ No

License No.	Date Issued

## BOARD CERTIFICATION

Are you certified by a recognized medical specialty examining board in the US or Canada? ☐ Yes ☐ No

Name of Certifying Body \_\_\_\_\_

**Certification Names and Dates** Indicate which primary, subspecialty and additional Board Certifications you have

Primary Board Certification Type	Initial Cert. Date	Last Recert. Date	Subspecialty Board Certification Type	Initial Cert. Date	Last Recert. Date	Tertiary Board Certification Type	Initial Cert. Date	Last Re-cert. Date

## EDUCATION

Please be as accurate and complete as possible. **Note:** If there is a break in chronology, please use a separate sheet to indicate activity/location/dates. If your medical degree was received from an institution outside the US, please send a copy of the diploma with English translation. If PhD, please provide copy of certificate.

	Name, City, State of Institution	Date Graduated	Degree
College or University			
Medical School			

## POSTGRADUATE TRAINING (e.g.: Intern, Resident, Fellow)\*

Name, City and State of Institution	Position or Title	Inclusive Dates

## ACADEMIC APPOINTMENTS

Both past and present. Fill in all sections, or write "none" if that is the case.\* Attach separate sheet for additional appointments

Name, City and State of Institution	Position or Title	Inclusive Dates

\*"See CV" is not acceptable.

## HOSPITAL APPOINTMENTS

Name, City and State of Institution	Position or Title	Inclusive Dates

## MILITARY SERVICE

Branch and Assignment	From	To

## PRACTICE SETTING

Which of the following best describes your primary work setting? (Choose one)

- ☐ Cardiovascular Group  
☐ Government Hospital or Agency-Military  
☐ Government Hospital or Agency-Other  
☐ Government Hospital or Agency-Veterans Affairs
- ☐ Industry (pharma, device)  
☐ Insurance Company (HMO, PPO, IPA)  
☐ Medical School/University  
☐ Multi-Specialty Group
- ☐ Non-governmental Hospital  
☐ Retired  
☐ Solo Practice  
☐ Other, please specify \_\_\_\_\_

What is the ownership structure of your practice? (Choose one)

- ☐ Government Owned   
 ☐ Hospital Owned   
 ☐ Insurance Company Owned   
 ☐ Medical School/University Owned
- ☐ Physician Owned   
 ☐ Not Sure   
 ☐ Other, please specify \_\_\_\_\_

## PROFESSIONAL TIME AND SPECIALIZATION(S)

Percentage of overall professional time devoted to the cardiovascular field \_\_\_\_\_ %

Of your CV professional work, rank the top three specialties you work on most by entering 1, 2 and 3.

- |  |                                     |                           |
|--|-------------------------------------|---------------------------|
| ___ Adult Congenital Cardiology            | ___ Echocardiology/Echocardiography | ___ Preventive Cardiology |
| ___ Cardiovascular Surgery                 | ___ Electrophysiology               | ___ Thoracic Surgery      |
| ___ Cardiovascular Research                | ___ MR Cardiology                   | ___ Vascular Medicine     |
| ___ Clinical Cardiology/General Cardiology | ___ Nuclear Cardiology              | ___ Other (specify) _____ |
| ___ CT Cardiology                          | ___ Pediatric Cardiology            |                           |

## AREAS OF INTEREST

Please indicate your top three areas of interest relevant to your primary clinical activities by entering 1, 2 and 3 below:

- |                                 |                                     |                              |                                  |
|---------------------------------|-------------------------------------|------------------------------|----------------------------------|
| ___ Administration              | ___ Endocrinology                   | ___ Nephrology               | ___ Public Health                |
| ___ Adult Cardiology            | ___ Family Practice                 | ___ Nuclear Cardiology       | ___ Pulmonary Disease            |
| ___ Adult Congenital Cardiology | ___ General Cardiology              | ___ Nuclear Medicine         | ___ Radiology                    |
| ___ Anesthesiology              | ___ Geriatrics/Aging and CV Disease | ___ Pathology                | ___ Research                     |
| ___ Arrhythmias and Devices     | ___ Health Policy                   | ___ Pediatric Cardiology     | ___ Sports & Exercise Cardiology |
| ___ Cardiac Rehab               | ___ Heart Failure/Transplant        | ___ Pediatric Interventional | ___ Thoracic Surgery             |
| ___ Cardiothoracic Surgery      | ___ Hypertension                    | ___ Cardiology               | ___ Transcatheter Valve Therapy  |
| ___ Congenital Cardiac Surgery  | ___ Internal Medicine               | ___ Pediatrics/Neonatal      | ___ Vascular & Interventional    |
| ___ Critical Care Medicine      | ___ Interventional Cardiology       | ___ Pharmacology             | ___ Radiology                    |
| ___ Echocardiography            | ___ Invasive Cardiology             | ___ Physical Medicine        | ___ Vascular Medicine            |
| ___ Electrophysiology           | ___ Lipids Clinic                   | ___ Physiology               | ___ Vascular Surgery             |
| ___ Emergency Medicine          | ___ MR/CT Cardiology                | ___ Preventive Cardiology    | ___ Other _____                  |

## WORK ACTIVITIES

Indicate % of work time devoted to each, totaling 100%

\_\_\_ % Research    \_\_\_ % Education    \_\_\_ % Clinical Practice    \_\_\_ % Administration    \_\_\_ % Other

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## DISCLOSURE

1. **Has your medical license ever been suspended, terminated or reduced in scope?**  
☐ Yes ☐ No If yes, please explain fully on separate page.
2. **Have you ever had hospital staff privileges denied, reduced in scope or rescinded for cause?**  
☐ Yes ☐ No If yes, please explain fully on separate page.
3. **Have you ever had disciplinary action taken against you at any time by a medical society, academic institution or government agency?**  
☐ Yes ☐ No If yes, please explain fully on separate page.
4. **Have you ever been convicted of, or plead guilty to, a felony or other serious crime?**  
☐ Yes ☐ No If yes, please explain fully on separate page.

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## APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I hereby consent to the release by any hospital, educational institution governmental agency, physician, professional society, or other person possessing or requiring the same, whether or not listed above, of any and all information in any way pertaining to my personal character, training, experience, or professional competence.

I agree that communications of any nature made to the College regarding my fitness for membership may be made in confidence and shall not be made available to me under any circumstances, I hereby release from any liability and all individuals and organizations or their authorized representatives who provide this information in good faith and without malice subject to this consent. I hereby release from all liability the American College of Cardiology and any and all individuals for their acts performed in good faith and without malice in connection with evaluation my application and my credentials and qualifications.

I hereby certify that all information recorded on this application and any attached document is accurate and supports my qualifications for membership in the American College of Cardiology for which I now apply. I hereby agree that the American College of Cardiology may verify any of the above data.

If elected, I agree to conform to the Bylaws of the College and its Code of Ethics. Information available to be can be found at [CardioSource.org/ethics](http://CardioSource.org/ethics).

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Signature of Applicant

Date

**Send your completed, signed application and payment to:**

**American College of Cardiology**  
ATTN: Member Services  
2400 N Street, NW  
Washington, DC 20037

**P:** (202) 375-6000, ext. 5439 | (800) 253-4636, ext. 5439

**E:** [membership@acc.org](mailto:membership@acc.org)