How to Apply: The Application Process

To apply, submit your application packet consisting of:

1. Completed Application Form
2. Have a current FACC, AACC or Cardiovascular Team member of the ACC fill out the attached sponsorship letter located at the end of the application form
3. Copy of your practicing license or applicable certification (see "Membership Criteria" for list of appropriate documentation)
4. Payment of Annual Dues and Nonrefundable Application Fee.

Annual Dues and Fees

Payment must be enclosed with application for processing.

Cardiovascular Team Membership Annual Dues	$110
Application Fee	$25
Total Payment to Accompany Application	**$135**

Mail your entire packet to:

American College of Cardiology Resource Center
2400 N Street, NW
Washington, DC 20037

P: (202) 375-6000, ext. 5603
(800) 253-4636, ext. 5603

Resource@acc.org

START APPLICATION HERE

AMERICAN COLLEGE of CARDIOLOGY

CARDIOVASCULAR TEAM APPLICATION

For Residents in the US and US Territories

Complete the application in its entirety. Please print or type ("See CV" is not acceptable)

I am applying as a:

- ❑ Clinical Nurse Specialist
- ❑ Clinical Pharmacist
- ❑ Clinical Psychologist
- ❑ Clinical Social Worker
- ❑ Exercise Physiologist
- ❑ Genetic Counselor
- ❑ Nurse Practitioner
- ❑ Occupational Therapist
- ❑ Physical Therapist
- ❑ Physician Assistant
- ❑ Registered Cardiac Electrophysiology Specialist
- ❑ Registered Cardiac Sonographer
- ❑ Registered Cardiovascular Invasive Specialist
- ❑ Registered Congenital Cardiac Sonographer
- ❑ Registered Diagnostic Cardiac Sonographer
- ❑ Registered Dietician
- ❑ Registered Nurse
- ❑ Registered Vascular Specialist
- ❑ Registered Vascular Technologist

PERSONAL DATA

Birth Date (Month/Day/Year) _____ Gender ❑ M ❑ F NPI #_____

Prefix First Name Middle Name Last Name Degrees Suffix

Race/Ethnicity

❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Native Hawaiian or Other Pacific Islander
❑ Hispanic or Latino ❑ Asian ❑ Other_____

MAILING ADDRESS

Please select preferred mailing address for ACC mail: ❑ Practice/Institution ❑ Home/Personal

Practice/Institution Contact Information

Practice/Institution Name Department Name

Practice/Institution Street Address City State/Province Postal Code Country

Phone

Home/Personal Contact Information

Home/Personal Street Address City State/Province Postal Code Country

Phone Fax

Email Address Please select preferred email address for ACC Communication ❑ Practice/Institution ❑ Home/Personal

Business Email Personal Email

PAYMENT

Payment must be included with application to ensure processing

Please enclose $135 with the application. (Payment of $110 dues + $25 application fee)

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

Card # CSC # (Required) *3-digit number on back of card or 4-digit on front of Amex* Exp.Date

❑ **Check** – payable in US funds drawn on a US bank. Check #_____ Amount _____

LICENSURE

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

License Number	License State/Province	License Country	Date Issued	License Type

BOARD CERTIFICATION

Primary Board Certifying Body	State	Date of Initial Certification	Date of Expiration	Certification Number

Subspecialty Board Certifying Body	State	Date of Initial Certification	Date of Expiration	Certification Number

EDUCATION

Education	Institution Name	Institution City/State/Country	Degree	Date Graduated
Undergraduate College/University				
Graduate/ Medical School				

POSTGRADUATE TRAINING – **Internships, Residency, Fellowship** (If applicable)

Institution Name	Institution City/State/Country	Position/Title	Start Date	End Date

APPOINTMENTS **(Hospital and/or Academic)**

Below please indicate all appointments held, both past and present. Indicate appointment type and fill in all sections, or write "none" if that is the case. Attach separate sheet for additional appointments.

Institution Name	Institution City/State/Country	Appointment Type	Position/Title	Start Date	End Date
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			

MILITARY SERVICE

Branch	Assignment	Start Date	End Date

PROFESSIONAL TIME/CLINICAL FOCUS

Indicate the **percentage of time** dedicated to the cardiovascular field _____%

Number of years in CV Practice _____

Indicate **percentage of work time** dedicated to each, totaling 100%

_____% Research _____ % Education _____ % Clinical Practice _____ % Administration _____ % Other

Rank the top three areas of clinical focus where you spend most of your professional time working in by entering 1, 2, and 3.

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

CURRENT SOCIETY MEMBERSHIPS

Society Name	Office Held (if any)	Membership Start Date

How did you hear about membership?

❑ ☐Email ❑ ☐Direct Mail ❑ ☐A current member: _____ ❑ ☐Print Ad ❑ ☐Web ❑ ☐Other Promo Code: _____

Please sign and date your application

Signature of Applicant Date

Check before you submit! Ensure your application is completed in full and all required elements listed under "How to Apply" are included with your application.

American College of Cardiology
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AMERICAN COLLEGE of CARDIOLOGY

ACC CARDIOVASCULAR TEAM MEMBERSHIP SPONSORSHIP FORM

Signed by a FACC, AACC or CVT member

As a member of the American College of Cardiology, it is my pleasure to recommend

_____

for Cardiovascular Team membership at the American College of Cardiology. His/her interest in cardiovascular medicine combined with proven ability makes him/her an excellent candidate for membership. Becoming a Cardiovascular Team member of the College will open up a new level of education and access to information that will ultimately benefit his/her patients and their families.

_____

Name of Sponsor (FACC, AACC or CVT member) Member ID Number

_____

Signature of FACC, AACC or CVT Sponsor Date

Mail or Fax to:

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Washington, DC 20037

Phone: (202) 375-6000, ext. 5603
(800) 253-4636, ext. 5603

Fax: (202) 375-6842

Note: This form can be mailed or faxed with the application or faxed directly from the sponsor's personal or business number. This form should not be used for the AACC sponsorship letter.