How to Apply: The Application Process

Applications are welcome on a rolling basis! Apply at any time throughout the year.

To apply, submit your application packet consisting of:

1. Completed Application Form
   - Make sure you include all relevant attachments, including copies of diplomas or certificates verifying appointments
2. Two sponsorship letters from current FACC or AACC Members
3. Proof of Board Certification
4. Payment of $25 Nonrefundable Application Fee.
   - Nonmembers should include $125 for annual dues.
   - Existing members: If your dues are not current, you must also pay them at the time of application.

Applications will be reviewed and accepted on a rolling basis.

Annual Dues and Fees

Payment must be enclosed with application for processing.

Annual Dues (Nonmembers)	$125
Application Fee	$25
CVT Section Membership (if not currently held)	$35

*Please Note: For existing members, if your membership dues are not current, you must include your annual dues payment with your application.

The following professional types are eligible to apply for AACC:

- Advanced Practice Nurses
- Physician Assistants
- Clinical Pharmacists
- Registered Nurses
- Clinical Exercise Physiologists
- Occupational Therapists
- Physical Therapists
- Clinical Psychologists

Mail your entire packet to:

American College of Cardiology Membership Services
2400 N Street, NW
Washington, DC 20037

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

Membership@acc.org

START APPLICATION HERE

AMERICAN COLLEGE of CARDIOLOGY

ASSOCIATE OF THE AMERICAN COLLEGE OF CARDIOLOGY (AACC) APPLICATION

For Residents in the US, US Territories and Canada

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_____

CONTACT INFORMATION

Preferred Mailing Address

Specify type: ❑ Practice/Institution ❑ Home/Personal

Street Address City State/Province Postal Code Country

Practice/Institution Name (If applicable) Department Name (If applicable)

Preferred Phone Specify type: ❑ Practice/Institution ❑ Home/Personal Fax

Preferred Email Specify type: ❑ Practice/Institution ❑ Home/Personal

Alternate Mailing Address (Not required)

Specify type: ❑ Practice/Institution ❑ Home/Personal

Street Address City State/Province Postal Code Country

Practice/Institution Name (If applicable) Department Name (If applicable)

Alternate Phone (Not required) Specify type: ❑ Practice/Institution ❑ Home/Personal Fax

Alternate Email (Not required) Specify type: ❑ Practice/Institution ❑ Home/Personal

PAYMENT

Payment must be included with application to ensure processing

Applicants must include the **application fee of $25 PLUS a fee of $35** for membership in the Cardiovascular Team Member Section, if not a current Section member, a requirement for AACC. Nonmember applicants should include an additional **$125** for payment of annual dues.

❑ MasterCard ❑ VISA ❑ American Express ❑ Discover *ACC does not accept any other credit cards* Promo Code: _____

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 _____

AMERICAN COLLEGE of CARDIOLOGY

ASSOCIATE OF THE AMERICAN COLLEGE OF CARDIOLOGY (AACC) APPLICATION

SPONSORS

Sponsors must be well acquainted with your professional activities. Important: Sponsors must meet requirements listed under "Membership Criteria".

Sponsor #1 Name | Street Address

City | State | Postal Code | Country

Sponsor #2 Name | Street Address

City | State | Postal Code | Country

LICENSURE

Are you currently licensed in your area of expertise? ☐❑ Yes ☐❑ No

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

BOARD CERTIFICATION

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

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

EDUCATION

If PhD, provide copy of certificate.

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

POSTGRADUATE TRAINING – Internships, Residency, Fellowship

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			

WORK SETTING & STRUCTURE

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
❑ Solo Practice

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

❑ Government Owned ❑ Hospital Owned ❑ Insurance Company Owned ❑ Medical School/University Owned
❑ Physician Owned ❑ Not Sure ❑ Other, please specify_____

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PROFESSIONAL TIME/CLINICAL FOCUS

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

Number of years in CV Medicine _____

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

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

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

___ Administration
___ 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
___ Research
___ Sports & Exercise Cardiology
___ Thoracic Surgery
___ Transcatheter Valve Therapy
___ Vascular & Interventional Radiology
___ Vascular Medicine
___ Vascular Surgery
___ Other _____

CVT MEMBER INVOLVEMENT

Please provide the names of any ACC committees, councils, task forces, writing committees, etc. that you have participated in since becoming a member of the College. (You may request this information from the ACC if you are unsure.)

_____

_____

_____

Please sign and date your application

_____

Signature of Applicant Date

Send your completed, signed application, sponsor letters, documentation and payment to:

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

Phone: (202) 375-6000, ext. 5439
(800) 253-4636, ext. 5439

E-mail: *membership@acc.org*