



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

I am applying as a: I am applying as a:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Registered Cardiac Sonographer | <input type="checkbox"/> Registered Diagnostic Cardiac Sonographer |
| <input type="checkbox"/> Clinical Pharmacist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Registered Cardiovascular Invasive Specialist | <input type="checkbox"/> Registered Dietician |
| <input type="checkbox"/> Clinical Psychologist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Registered Congenital Cardiac Sonographer | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Clinical Social Worker | <input type="checkbox"/> Physician Assistant | | <input type="checkbox"/> Registered Vascular Specialist |
| <input type="checkbox"/> Exercise Physiologist | <input type="checkbox"/> Registered Cardiac Electrophysiology Specialist | | <input type="checkbox"/> Registered Vascular Technologist |
| <input type="checkbox"/> Genetic Counselor | | | |

PERSONAL DATA

Birth Date (Month/Day/Year) _____

Gender M F

NPI # _____

Prefix	First Name	Middle Name	Last Name	Degrees	Suffix
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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
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Practice/Institution Street Address	City	State/Province	Postal Code	Country
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Phone

Home/Personal Contact Information

Home/Personal Street Address	City	State/Province	Postal Code	Country
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Phone	Fax
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Email Address Please select preferred email address for ACC Communication Practice/Institution Home/Personal

Business Email	Personal Email
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PAYMENT

 Payment must be included with application to ensure processing

Please enclose \$125 with the application. (Payment of \$100 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
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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
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BOARD CERTIFICATION

Primary Board Certifying Body	State	Date of Initial Certification	Date of Expiration	Certification Number
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Subspecialty Board Certifying Body	State	Date of Initial Certification	Date of Expiration	Certification Number
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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
		<input type="checkbox"/> Hospital <input type="checkbox"/> Academic			
		<input type="checkbox"/> Hospital <input type="checkbox"/> Academic			
		<input type="checkbox"/> Hospital <input type="checkbox"/> Academic			
		<input type="checkbox"/> Hospital <input type="checkbox"/> Academic			
		<input type="checkbox"/> Hospital <input type="checkbox"/> 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.

- | | | | |
|----------------------------------|--------------------------------------|--|--|
| ____ 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 | ____ Heath Policy | ____ Pediatric Cardiology | ____ Sports & Exercise Cardiology |
| ____ Cardiac Rehab | ____ Heart Failure/Transplant | ____ Pediatric Interventional Cardiology | ____ Thoracic Surgery |
| ____ Cardiothoracic Surgery | ____ Hypertension | ____ Pediatrics/Neonatal | ____ Transcatheter Valve Therapy |
| ____ Congenital Cardiac Surgery | ____ Internal Medicine | ____ Pharmacology | ____ Vascular & Interventional Radiology |
| ____ Critical Care Medicine | ____ Interventional Cardiology | ____ Physical Medicine | ____ Vascular Medicine |
| ____ Echocardiography | ____ Invasive Cardiology | ____ Physiology | ____ Vascular Surgery |
| ____ Electrophysiology | ____ Lipids Clinic | ____ Preventive Cardiology | ____ Other _____ |
| ____ Emergency Medicine | ____ MR/CT Cardiology | | |

CME/CE INTEREST AREAS

Outside of your clinical focus, please check off **your top three areas of interest** in cardiovascular practice.

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

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: **FUSTER2015**

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
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



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:

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

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.