Membership Criteria

All applicants must:

- Hold membership in a recognized Health IT society or obtain a letter of recommendation from a current member of the ACC. Society memberships accepted include:
  - Healthcare Information and Management Systems Society
  - eHealth Initiative
  - American Association of Healthcare Administrative Management
  - Medical Group Management Association
  - European Association of Healthcare IT Managers
  - American Health Information Management Association
  - American Medical Informatics Association
- Hold a current role as a data manager or health IT manager within their current institution or practice
- Have an advanced degree in IT (BS or above) or active participation with an ACC or STS data registry
- Spend the majority of their professional time engaged in non-clinical activities. Those cardiovascular team members who spend the majority of their time in clinical engagements should apply via the Cardiovascular Team membership category.

How to Apply: The Application Process

To apply, submit your application packet consisting of:

1. Completed Application Form
   - Make sure you include all relevant attachments, including a signed sponsorship letter IF you are not a current member of a recognized Health IT society
2. Payment of Annual Dues and Nonrefundable Application Fee.

Annual Dues and Fees

Payment must be enclosed with application for processing.

Affiliate Annual Dues	$100
Application Fee	$25
Total Payment to Accompany Application	**$125**

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

AFFILIATE APPLICATION FOR HEALTH CARE INFORMATION TECHNOLOGY SPECIALISTS

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

PERSONAL DATA

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

Prefix First Name Middle Name Last Name Suffix Degrees

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 | Job Title

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

Phone | Fax

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 include $125 US with the application. ($100 annual dues + $25 one-time 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 _____

AMERICAN COLLEGE of CARDIOLOGY

AFFILIATE APPLICATION FOR HEALTH CARE INFORMATION TECHNOLOGY SPECIALISTS

Note: In the following sections we will collect information about your education and appointments. Please be as complete as possible. **If there is a break in chronology, please use a separate sheet to indicate activity, location and dates.**

EDUCATION

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

APPOINTMENTS (Hospital and/or Academic) If Applicable

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

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 practice? (Choose one)

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

My practice/institution actively participates in an ACC or STS Registry *Required if lacking advanced degree in IT:

❑ Yes ❑ No ❑ NCDR Participant ID_____

AMERICAN COLLEGE of CARDIOLOGY

AFFILIATE APPLICATION FOR HEALTH CARE INFORMATION TECHNOLOGY SPECIALISTS

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 clinical focus areas 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 _____

CURRENT SOCIETY MEMBERSHIPS

Please indicate the Health IT society of which you are currently a member. See list under "Membership Criteria" for societies accepted in lieu of a sponsorship letter.

Name	Office Held (if any)	Membership Start Date

How did you hear about membership?

❑ □Email ❑ □Direct Mail ❑ □Recruited By:_____ ❑ □Print Ad ❑ □Web ❑ □Other Promo Code: _____

Send your completed application, sponsor form letter if applicable, documentation and payment to:

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

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

E-mail: *resource@acc.org*

AMERICAN COLLEGE of CARDIOLOGY

ACC AFFILIATE MEMBERSHIP SPONSORSHIP FORM

Signed by an ACC member

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

_____

for Affiliate membership at the American College of Cardiology. His/her interest in cardiology and health information technology combined with proven ability makes him/her an excellent candidate for membership. Becoming an Affiliate 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 (Must be a current ACC member) Member ID Number

_____

Signature of ACC Member Sponsor Date

Mail or Fax to:

American College of Cardiology
ATTN: Resource Center
2400 N Street, NW
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.