AMERICAN COLLEGE of CARDIOLOGY

FELLOW/ASSOCIATE FELLOW APPLICATION

Residents in the US, US Territories and Canada

Application must be completed in its entirety in print or type. "See CV" is not acceptable.

Additional application forms can be found at *CardioSource.org/Join*.

PERSONAL DATA

Applying for: ❑ Fellow ❑ Associate Fellow

Birth Date (MM/DD/YYYY) _____ Gender ❑ M ❑ F NPI#_____

Prefix First Name Middle Name Last Name Suffix

Race/Ethnicity ❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino ❑ Asian ❑ Other _____

Mailing Address Check 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: ❑ Work ❑ Home

Business Email_____ Personal Email _____

PAYMENT Payment must be included with application.

- New members should include US $770 for dues, US $150 for nonrefundable application fee for a total of US $920. State chapter dues will be assessed for a new member in the next billing year.
- New members applying from Canada should include US $435, plus $150 application fee for a total US $585.
- An advancing member needs only to include the application fee if all dues obligations are filled. (Contact membership services with questions)

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

Card # _____ CSC # (REQUIRED) _____ Exp. Date _____

3 DIGIT NUMBER ON BACK OF CARD OR FRONT OF AMEX CARD

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

SPONSORS

Please list the names of your sponsors. Applicants are required to obtain two letters of sponsorship from two Fellows of the College, which must adhere to specific criteria for the application to be processes or reviewed. **Important:** please refer to requirements listed on previous page.

1. _____, FACC _____
   Name Street Address, City, State

2. _____, FACC _____
   Name Street Address, City, State

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? Please indicate:

___ Advisory Board for Osteopathic Specialists of the American Osteopathic Association

___ American Board of Internal Medicine

___ American Board of Pediatrics

___ American Board of Thoracic Surgery

___ Canadian Royal College of Physicians and Surgeons

___ Professional Corporation of Physicians of Quebec

___ If from another country, name country and board:

_____

_____

_____

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 Recert. Date
Internal Medicine			Cardiovascular Disease			Adult Congenital Heart Disease		
Pediatric Medicine			Pediatric Cardiology			Electrophysiology		
Surgery			Thoracic Surgery			Heart Failure & Trans-plant		
Other:			Other:			Other:		

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.

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

POSTGRADUATE TRAINING - Appointments (e.g.: Intern, Resident, Fellow)*

Please enclose copies of all certificates.

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

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

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
- ❑ 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 Cardio9logy
- ❑ 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 _____

WORK ACTIVITIES

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

___% Research ___ % Education ___% Clinical Practice ___% Administration ___% Other

Current Medical Society Membership(s)

_____

_____

PUBLICATIONS

If applying through the academic/science track, a bibliography must be included. In order for your application to be evaluate fairly, please organize your bibliography using the format below; otherwise, your application will be considered incomplete and will not be reviewed. List precisely as published with the authors, title of article, name (volume, page and date) of journal. Provide the name of the index where each publication is listed, or state "not indexed" if that is the case. **Do not send reprints of articles, abstracts, etc.**

❑ **Check here if you do not have any publications**

List and number in separate categories as follows:

(1) Published papers in cardiovascular-related peer-reviewed journals

(2) Textbook chapters, invited articles and reviews

(3) Published abstracts

(4) Miscellaneous

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.

Applicant's Authorization to Release Information

I hereby conset 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*.

_____

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
P: (202) 375-6000, ext. 5439 | (800) 253-4636, ext. 5439
E: membership@acc.org