Membership Criteria

To apply for International Cardiovascular Team membership, candidates must fall into one of the below categories and meet requirements for membership

Registered Nurse

Applicants must have an RN degree and be licensed to practice.

Nurse Practitioner

Applicants must have an RN degree and be an NP licensed to practice.

Clinical Nurse Specialist

Applicants must have an RN degree, along with a certification in the area of clinical practice and be licensed to practice.

Physician Assistant

Applicants must be a graduate of a PA program. Applicants must also be licensed to practice in the area in which they are employed.

Clinical Pharmacist

Applicants must have a Clinical Pharmacist's PharmD degree and be licensed to practice.

Genetic Counselor

Applicants must be licensed to practice in their area of employment.

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
2. Have a current FACC, AACC or Cardiovascular Team member of the ACC fill out the attached sponsorship letter
3. Copy of your practicing license
4. Payment of Annual Dues and Nonrefundable Application Fee.

Annual Dues and Fees

Payment must be enclosed with application for processing.

International Cardiovascular Team Annual Dues	$55
Application Fee	$25
Total Payment to Accompany Application	**$80**

Send 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

INTERNATIONAL CARDIOVASCULAR TEAM APPLICATION

For residents outside 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:

❑ Registered Nurse ❑ Nurse Practitioner ❑ Genetic Counselor
❑ Clinical Nurse Specialist ❑ Clinical Pharmacist ❑ Physician Assistant

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 include US$80 with the application.

❑ 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 _____

INTERNATIONAL CARDIOVASCULAR TEAM APPLICATION

LICENSURE

Are you currently licensed to practice medicine? ☐❑ 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 (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 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.

___ 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

Medical 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

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

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

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

E-mail: *resource@acc.org*

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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:

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. This form should not be used for the AACC sponsorship letter.