ACCP
AMERICAN COLLEGE OF CORRECTIONAL PHYSICIANS

Print your name as you wish it to appear on your badge and other correspondence.

Name: _____ Degree(s)_____

Job Title:_____ Place of Work: _____

Mailing Address:_____

City: _____ State: _____ Zip: _____

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Membership Fees Please ☐ begin/ ☐ renew my membership in the ACCP

☐ Physicians.....$150 ☐ Physician Assistants, Nurse Practitioners, and Dentists.....$100

Meeting Fees	**Thru 10/8**	**After 10/8 & Onsite**
☐ ACCP Member.....	$200	$250
Academy of Correctional Health Professionals – RN's, LPN's or Admin	$150	$200
Academy of Correctional Health Professionals – MD, PA, DDS, or NP	$225	$275
☐ Nonmembers.....	$245	$295
☐ In-Training – Medical Student, Resident/Fellow	$75	$100

Payment Information **Total Enclosed:** ____

☐ Enclosed is my check made payable to the American College of Correctional Physicians

Please bill my ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

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For New and Renewing Members

By my signature, I attest that I am a doctor of medicine, osteopathy, or dentistry who holds a license to practice medicine by an appropriate board of licensure that does not limit my practice solely to the correctional setting or I am a Physician Assistant or Nurse Practitioner, and am engaged in the practice, teaching or research of correctional medicine. I certify that my renewal application as submitted is true and correct. I agree to comply with ACCP's bylaws and code of ethics.

Signature: _____Date:_____

Return this registration form, along with payment, to:

American College of Correctional Physicians
5404 S. Taft Ct.
Littleton, CO 80127
Phone: 720-646-2978 · Fax: 303-988-2956