ACCP
AMERICAN COLLEGE OF CORRECTIONAL PHYSICIANS

Membership Application

The ACCP does not discriminate in membership based on race, religion, national origin, sex or handicap.

O Join O Renew My ACCP Membership

Your name should be submitted as you want it to appear on official correspondence. Please print.

First Name____________________Middle Initial______
Last Name____________________________________
Degree(s)____________________________________
Job Title________________________________
Place of Work____________________________

Mailing Address______________________________
City__________________ State_______ Zip__________

Other Address ___________________________________

City____________________State ___ Zip _________

Work Phone_______________Mobile________________
Other _______________

Email____

Professional Training

O Physician O Psychiatrist
O Physician Assistant O Nurse Practitioner
O Dentist
O In Training (Student/Resident)

Are you Board certified? O Yes O No
If yes, specialty_________________________________

Please Choose Membership Level

Physician (*Full Member*)

O $175 (1 yr) O $315 (2 yrs) O $425 (3 yrs)

PA, NP, DDS, PharmD, DPM, OD, Mental Health professionals with a Doctorate (*Associate Member - Non-Voting*)

O $120 (1 yr) O $225 (2 yrs) O $335 (3 yrs)

In Training (Student or Resident) (*Non-Voting*)

O FREE

Verification of Eligibility

1. Do you currently have an unrestricted license to practice?
   O Yes O No (If no, please provide details separately)
2. Has your license ever been suspended or revoked?
   O Yes O No (If yes, please provide details separately)
3. Have you ever been convicted of a felony offense?
   O Yes O No (If yes, please provide details separately)
4. What graduate school did you attend?
   ________________________Year of Graduation__________
5. Are you an AMA member?
   O Yes O No

Application Statement

I am applying for membership in the American College of Correctional Physicians. By my signature, I attest that I am either 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, Nurse Practitioner, student, or resident interested in the practice, teaching or research of correctional medicine. I certify that my application as submitted is true and correct. I agree to comply with ACCP's bylaws and code of ethics.

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Signature Date

Payment Information

O Paid Onsite via Credit Card / PayPal

O Enclosed a check, payable to ACCP

Please bill my:

O MasterCard O Visa O American Express O Discover

Card Number_______________________________
Expiration Date_______ Security Code______

Billing Address_____________________________
City__________________State_____Zip______
Signature___________________________________

Return this registration form along with payment to:

ACCP, Attention: Christine Westbrook, 14 Coves End Rd., Marion, MA 02738
Phone: 720-646-2978 · Fax: 774-553-5955