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:

O $150 (1 yr) O $265 (2 yrs) O $360 (3 yrs)

PA, NP, DDS, PharmD, DPM, OD and Mental Health professionals with a Doctorate:

O $100 (1 yr) O $190 (2 yrs) O $285 (3 yrs)

In Training (Student or Resident):

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.

_____

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:

American College of Correctional Physicians, 14 Coves End Rd., Marion, MA 02738
Phone: 720-646-2978 · Fax: 774-553-5955