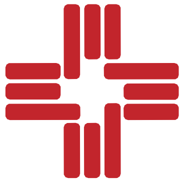

ACCP
AMERICAN COLLEGE OF CORRECTIONAL PHYSICIANS

Membership Application -

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

O Begin 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)____________________________________
JobTitle _________________________________Place of Work ________________________________

Mailing Address _______________________________
City ____________________State ___ Zip __________

Other Address ________________________________

City ____________________State ___ Zip __________

Phone _______________Fax ________________Mobile
Other ________________Email_____________________

Professional Training

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

If applicable 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 $400 (3 yrs)

Physician Assistant, Nurse Practitioners, and Dentists:

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

In Training (Student/Resident/Fellow):

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, resident, or fellow 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

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