



Membership Application -

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

Begin 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 _____

Phone _____ Fax _____ Mobile _____

Other _____ Email _____

Professional Training

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

If applicable are you Board certified? Yes No
If yes, specialty _____

Please Choose Membership Level

Physician:

- \$150 (1 yr) \$265 (2 yrs) \$400 (3 yrs)

Physician Assistant, Nurse Practitioners, and Dentists:

- \$100 (1 yr) \$190 (2 yrs) \$285 (3 yrs)

In Training (Student/Resident/Fellow):

- FREE

Verification of Eligibility

- Do you currently have an unrestricted license to practice?
 Yes No (If no, please provide details separately)
- Has your license ever been suspended or revoked?
 Yes No (If yes, please provide details separately)
- Have you ever been convicted of a felony offense?
 Yes No (If yes, please provide details separately)
- What graduate school did you attend?
_____ Year of Graduation _____
- Are you an AMA member?
 Yes 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

- Paid Onsite via Credit Card
 Enclosed a check, payable to ACCP

Please bill my:

- MasterCard Visa American Express Discover

Card Number _____
Expiration Date _____ Security Code _____

Billing Address _____
City _____ State ____ Zip _____
Signature _____

Return this registration form, along with payment, to: