

Allied Membership Application

We are pleased that you are interested in joining the American College of Chest Physicians (ACCP), a multidisciplinary, international medical society with more than 17,000 active members in more than 100 countries.

REQUIREMENTS FOR ALLIED MEMBER

Qualifications

An Allied Member shall be a nonphysician, nondoctoral, nonstudent health professional or medical practice administrator who works in a field related to pulmonary, critical care, sleep medicine, thoracic surgery, or a related discipline.

- The candidate shall either (1) provide direct patient care, department supervision at a hospital, or medical practice administration or; (2) engage in clinical, academic, or research activities. In either case, the qualifying professional activities should be devoted to pulmonary, critical care, sleep medicine, thoracic surgery or a related discipline. On a case-by-case basis, the Membership Committee may consider candidates having other specialties.
- Candidates other than medical practice administrators must have proof of professional certification, licensure, or registry.
- Candidates who do not work in a clinical setting must submit a letter from a direct supervisor describing the person's current professional responsibilities.
- Persons who are only tangentially involved in the provision of care do not qualify. Examples include sales and marketing professionals, industry scientific liaisons, business consultants, market researchers, and financial advisers.

Rights and Privileges of Allied Members

Allied Members shall have limited rights and privileges of membership.

NETWORKS/INSTITUTES – A FREE MEMBER BENEFIT

NetWorks are interdisciplinary interest groups providing the opportunity for your personal and professional alliance with the ACCP. You are encouraged to get involved in ACCP activities by joining one or more NetWorks. Each NetWork meets once a year at the annual CHEST meeting and communicates throughout the year via e-mail and teleconference.

Please indicate your NetWork/Institute choice(s) in the list below. Your e-mail address will automatically be added to the mailing list for each one you select. For more information about the individual NetWorks, refer to ACCP's Web site: www.chestnet.org.

- | | | |
|--|---|---|
| <input type="checkbox"/> Affiliate | <input type="checkbox"/> Home Care | <input type="checkbox"/> Pulmonary Physiology, Function, and Rehabilitation |
| <input type="checkbox"/> Airways Disorders | <input type="checkbox"/> Interstitial and Diffuse Lung Disease | <input type="checkbox"/> Pulmonary Vascular Disease |
| <input type="checkbox"/> Allied Health | <input type="checkbox"/> Interventional Chest/Diagnostic Procedures | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Cardiovascular Medicine and Surgery | <input type="checkbox"/> Members in Industry | <input type="checkbox"/> Sleep Institute |
| <input type="checkbox"/> Chest Infections | <input type="checkbox"/> Occupational and Environmental Health | <input type="checkbox"/> Thoracic Oncology |
| <input type="checkbox"/> Clinical Pulmonary Medicine | <input type="checkbox"/> Palliative and End-of-Life Care | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Critical Care Institute | <input type="checkbox"/> Pediatric Chest Medicine | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Cultural Diversity in Medicine | <input type="checkbox"/> Practice Operations | |
| <input type="checkbox"/> Disaster Response | | |

CONTACT INFORMATION

Please print all information, and list your name EXACTLY as you would have it appear on all official documents.
An incomplete application will delay the review process.

Last Name	First Name	Middle Initial
Country of Birth ()	Date of Birth (Month/Day/Year) <i>Confidential - Required for online authentication</i> ()	<input type="checkbox"/> Male <input type="checkbox"/> Female
Office Phone Number ()	Fax	
Home Phone Number (<i>confidential</i>)	E-mail Address (<i>Required</i>)	

Primary Address Home Office

This is the address that will be used for ACCP mailings. This address will appear in the online Membership Directory if no other address is listed under Directory Address below.

Line 1

Line 2

Line 3

City/State/Zip **or** City/Province/Country/Postal Code

Directory Address (optional) Home Office

Line 1

Line 2

Line 3

City/State/ Zip **or** City/Province/Country/Postal Code

Active Military Service (US applicants only)

Rank

Branch

Payment (required for processing)

- \$60 (USD) – Allied member dues (includes the journal *CHEST* online only)
- \$144 (USD) – Allied member dues (includes the journal *CHEST* print and online)

Credit Card Payment (preferred)

- VISA American Express Mastercard

Credit Card Number

Expiration Date (MM) (YY)

Signature

Date

Check Payment

Check/Money Order No. (in US currency drawn on a US bank)
Payable to: American College of Chest Physicians

FOR OFFICE USE ONLY

ACCP Account Number

EDUCATION BACKGROUND/PROFESSIONAL EXPERIENCE

Degree	Name and Location of Institution(s)	Degree	Date Received
Undergraduate			
Postgraduate (MHA, MHSA, MS, etc)			

Time Allocation

Percentage of employment devoted to direct patient care; department supervision at a hospital; medical practice administration; clinical, academic, or research in pulmonary, critical care, sleep medicine, thoracic surgery, or a related discipline _____ %

Brief Description of Your Professional Responsibilities (Required)

Current Employment

<p>Employment Type</p> <input type="checkbox"/> Chair/Chief/Head/Director not TPD <input type="checkbox"/> Corporation <input type="checkbox"/> Government Hospital <input type="checkbox"/> Group Practice (5 or Less)	<input type="checkbox"/> Group Practice (>5) <input type="checkbox"/> Home Health Care <input type="checkbox"/> Industry (equipment/device) <input type="checkbox"/> Industry (pharmacologic) <input type="checkbox"/> Medical Director of Respiratory Care	<input type="checkbox"/> Training Program <input type="checkbox"/> Private Hospital <input type="checkbox"/> Self-Employed Solo Practice <input type="checkbox"/> Sleep Medicine Laboratory	<input type="checkbox"/> HMO <input type="checkbox"/> Teaching/Academic <input type="checkbox"/> Veterans Affairs (VA) <input type="checkbox"/> Other _____
---	---	--	--

Title _____ Institution and Location _____

<p>Primary Activity</p> <input type="checkbox"/> Administration <input type="checkbox"/> Clinical Care <input type="checkbox"/> Consulting <input type="checkbox"/> Industry <input type="checkbox"/> Research <input type="checkbox"/> Teaching <input type="checkbox"/> Other _____	<p>Allied Medical Specialties</p> <input type="checkbox"/> Cardiovascular Perfusion <input type="checkbox"/> Clinical Education <input type="checkbox"/> Clinical Research <input type="checkbox"/> Critical Care Medicine/ Surgery <input type="checkbox"/> Dietetics	<input type="checkbox"/> Education (Academic Employer) <input type="checkbox"/> Exercise Physiology <input type="checkbox"/> Home Health Care <input type="checkbox"/> Hospital Administration <input type="checkbox"/> Practice Administration <input type="checkbox"/> Pulmonary Medicine	<input type="checkbox"/> Sleep Medicine <input type="checkbox"/> Other _____
--	---	--	---

Current Boards/Certifications (if applicable)	Date Issued	Date Retaken

I release and discharge the American College of Chest Physicians (ACCP), its Officers, Regents, Governors, and employees, from all claims, actions, damages, and expenses of any kind arising from any action taken on this application..

Signature _____ **Date** _____

RETURN SIGNED AND COMPLETED APPLICATION WITH YOUR PAYMENT TO:

ACCP Membership
 American College of Chest Physicians
 3300 Dundee Road, Northbrook, Illinois 60062-2348 USA
 or Fax to: (847) 498-5460