

# Allied Health Membership Application

## Enjoy the Benefits of ACCP Allied Health Membership!

We are pleased that you are interested in joining the American College of Chest Physicians (ACCP).

The ACCP is a multidisciplinary international medical society with over 16,000 active members representing the patient care team in over 100 countries.

### YOU QUALIFY IF:

You are a nonphysician health-care professional engaged in clinical, academic, research, or administrative work related to cardiopulmonary medicine, surgery, critical care medicine, or sleep medicine, among other specialties.

As a member of our multidisciplinary society, you have access to a diverse array of the listed benefits designed for your professional and personal advancement.

For an annual membership fee of only \$60, you receive:

- Reduced fee for the ACCP annual scientific assembly, CHEST. This is an unparalleled program of clinical and scientific information.
- Discounted fee for postgraduate courses
- Eligibility for participation in all NetWorks, including the Allied Health NetWork (special interest groups providing education, networking, and leadership opportunities)
- ACCP news publications
- Special “members only” communications, describing major issues confronting your profession
- A listing in the online ACCP membership directory

**Allied Health Membership is an important reflection of the entire health-care team.**

## REQUIREMENTS FOR ALLIED HEALTH MEMBERSHIP

Any nonphysician health-care professional who is engaged in clinical, academic, research, or administrative work related to cardiopulmonary medicine, surgery, critical care medicine, or sleep medicine, among other specialties, may be considered for association with the ACCP as an Allied Health Member.

The Allied Health Member category is for the nonphysician allied health professionals or administrators who provide direct patient care, department supervision at a hospital, practice administration, or engage in clinical, academic, or research activities.

At least 50% of the candidate's professional time must be spent in work related to cardiopulmonary diseases. All Allied Health categories, with the exception of practice administrator, must include proof of certification, licensure, or registry. A minimum of 2 years' experience in the field is necessary for all candidates. After the application is reviewed and all criteria are met, the candidate will be accepted upon payment of dues.

Allied Health Membership dues are \$60 per year and do not include the *CHEST* journal, in print or online. This \$60 must accompany the application form in order for the form to be processed.

### Please note:

You may receive the *CHEST* journal, for an additional \$60 for United States residents or \$84 for Canadian and international residents.

We look forward to having you as a member of the American College of Chest Physicians.

## NETWORKS – 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 choice(s) in the list below. Your e-mail address will automatically be added to the mailing list for each NetWork you select. For more information about the individual NetWorks, please refer to ACCP's Web site: [www.chestnet.org](http://www.chestnet.org). Please be advised that you will receive quarterly e-mail communications from each NetWork you select below.

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

# Allied Health Membership Application

## CONTACT INFORMATION

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

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name Middle Initial

\_\_\_\_\_  
Country of Birth

\_\_\_\_\_  
Date of Birth Month / Day / Year  Male  Female

Confidential - Required for online authentication

**Primary Address** Specify:  Home  Office

This is the address that will be used for the 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) Specify:  Home  Office

\_\_\_\_\_  
Line 1

\_\_\_\_\_  
Line 2

\_\_\_\_\_  
Line 3

\_\_\_\_\_  
City / State / Zip or City / Province / Country / Postal Code



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Phone: (847) 498-1400 • Fax: (847) 498-5460  
E-mail: member@chestnet.org • Web: www.chestnet.org

## Telephone Numbers

(\_\_\_\_\_) \_\_\_\_\_  
Office Phone

(\_\_\_\_\_) \_\_\_\_\_  
Fax

(\_\_\_\_\_) \_\_\_\_\_  
Home Phone (confidential)

\_\_\_\_\_  
E-mail Address

## Active Military Service (US applicants only)

\_\_\_\_\_  
Rank Branch

## Payment

- \$60 (USD) – Allied Health Member Dues (does not include the *CHEST* journal)
- \$120 (USD) – Allied Health Member Dues, including the *CHEST* journal, in print and online for residents of the United States.
- \$144 (USD) – Allied Health Member Dues, including the *CHEST* journal, in print and online for Canadian and international residents.

## Credit Card Payment (preferred payment)

- VISA  American Express  Mastercard

\_\_\_\_\_  
Credit Card Number Expiration Date

\_\_\_\_\_  
Signature Date

## Check Payment

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

**FOR OFFICE USE ONLY**

\_\_\_\_\_  
Application Number

## EDUCATIONAL BACKGROUND/PROFESSIONAL EXPERIENCE

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

### Credentials

Present Position	Title
Institution	
Street Address	City
State / Province / Country	Zip Code / Postal Code

**Percentage of total professional activity devoted to cardiopulmonary-related care \_\_\_\_\_ %**

<p><b>RN</b></p> <input type="checkbox"/> Respiratory Care <input type="checkbox"/> ICU <input type="checkbox"/> Research <input type="checkbox"/> Critical Care <input type="checkbox"/> Educator <input type="checkbox"/> Cardiac <input type="checkbox"/> Pulmonary Rehabilitation <input type="checkbox"/> Home Health <input type="checkbox"/> Other	<p><b>APN (Advanced Practice Nurse)</b></p> <input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> CRNA <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Educator <input type="checkbox"/> Other  <p><b>PA</b></p> <input type="checkbox"/> Patient Care <input type="checkbox"/> Respiratory Care Education <input type="checkbox"/> Cardiopulmonary Specialist <input type="checkbox"/> Other	<p><b>RRT</b></p> <input type="checkbox"/> Pulmonary Rehab Therapist <input type="checkbox"/> Respiratory Care Director <input type="checkbox"/> Administrative <input type="checkbox"/> Research <input type="checkbox"/> Staff Therapist <input type="checkbox"/> Sleep Tech <input type="checkbox"/> Educator <input type="checkbox"/> Other  <p><b>CCP</b></p> <input type="checkbox"/> Other	<p><b>BA/BS</b></p> <input type="checkbox"/> Sleep Lab Tech <input type="checkbox"/> Pulmonary Function Lab Tech <input type="checkbox"/> Research Associate <input type="checkbox"/> Other  <p><b>OTR, PT</b></p> <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Cardiopulmonary Specialist <input type="checkbox"/> Respiratory Care Education <input type="checkbox"/> Research <input type="checkbox"/> Other
<input type="checkbox"/> <b>Practice Administration</b> _____ (Title)	<input type="checkbox"/> <b>Other</b> _____ (Title)		

### Certification Boards/Registry/Certification (if applicable)

State/Province/Country/National Board	Number	Date Issued	Exp. Date

Until I expressly revoke my consent, by signing this document, I hereby consent to the American College of Chest Physicians (ACCP) sending to me materials advertising the commercial availability or quality of ACCP's property, goods, or services.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_