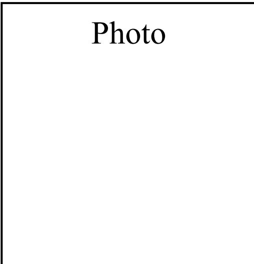
American College of Independent Medical Examiners

# MEMBERSHIP

6470-A Merritts Creek Road
Huntington, WV 25702
Phone: (304) 733-0095 * Fax: (304) 733-5243
Website: www.acime.org




COMPLETE YOUR PERSONAL/PROFESSIONAL INFORMATION

## Personal Information:

**NAME:** (Please leave one blank space between first, middle and last names.)

Last Name First Name M.I.

**DEGREE:** ☐ MD ☐ DO ☐ MBBS ☐ MBCHB ☐ FRCS ***OTHER:***________________

**ADDRESS:** (Check **one** preferred address that will be used by this office for all mailings until you advise us of a change)

**Home Address:** (☐ Preferred)

City State/Province Country Postal/Zip Code

## Professional Information: Specialty:________________________________________

**Company/Organization:**

**Business Address:** (☐ Preferred)

City State/Province Country Postal/Zip Code

**Training:** (Please list)

Medical School/University: ________________________________________Year Graduated: __________

Residency/Specialty Training Institution: ____________________________________________________

City State/Province Country Postal/Zip Code

ABMS Certification(s) or Other Specialty Boards/Colleges name: ________________________________

______________________________________________________________________________________

Licensed/Registered to Practice in (States/Provinces/Countries): ______________________________________

**<u>Telephone/Fax/Email Information</u>:** (This information is required and would not be sold for marketing)

Business PH: ( ____ ) ____________________ Fax: ( ____ ) ____________________

Home PH: ( ____ ) ___________________ Mobile/Cell PH: ( ____ ) _________________

E-Mail: ______________________________________________________

## SIGN THE ACIME PROFESSIONAL CODE OF CONDUCT

The ***ACIME*** Code of Ethics applies to health professionals who are engaged in the practice of Disability Medicine, and addresses distinctive ethical issues that are characteristic of this field. For the entire *Code of Ethics* go to ACIME website at www.acime.org and read it carefully and in its entirety.

**All information given/provided as part of this application is accurate and complete and if approved for membership, I hereby pledge to comply with ACIME's *Code of Ethical Conduct* as required by ACIME's bylaws.**

Signature: ________________________________________________ Date: _____________________

## PLEASE SELECT YOUR MEMBERSHIP CATEGORY AND COMPLETE THE PAYMENT INFORMATION

Please review the entire requirements for the particular membership category that you are applying for at www.acime.org . You are responsible for all of the documentation required to support your application.

**<u>Membership Categories and Annual Dues</u>:** ☐ **Full $199** ☐ **Associate $150**

***<u>DUES TOTAL</u>*:** $_______________ $_______________ $_______________

*Annual Dues* *Other Dues* *Total Due*

***<u>PAYMENT METHOD:</u>***

☐ **Payment by Check**: Please make check payable to **<u>ACIME</u>**

☐ **Payment by Credit Card:** ☐ **Visa** ☐ **MasterCard** ☐**Amex** ☐**Discover**

**Card Number: _________________________________ Exp. Date: ____/____ CCV Code: ______**

**Signature: _______________________________________________ Date: _____________**

## HOW TO SUBMIT YOUR APPLICATIONS

Please include your current **CV**, **Copy of Medical License/Registration**, and **2 letters of Recommendation.**

***<u>FAX</u>:*** this application and supporting documentation with your credit card information to **304-733-5243**
***<u>MAIL</u>:*** this application and supporting documentation with your payment to:
**ACIME, 6470-A Merritts Creek Road, Huntington, WV 25702**
***<u>E-MAIL</u>:*** you can also scan and email application and credit card payment to: **info@acime.org**