American College of Independent Medical Examiners

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

MEMBERSHIP APPLICATION

Photo

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): _____

Telephone/Fax/Email Information: (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.

Membership Categories and Annual Dues: ☐ **Full $195** ☐ **Junior $150** ☐ **Associate $95**

***DUES TOTAL*:** **$**_____
Annual Dues
$ 50.00 ***(Required)***
Application Fee
$_____
TOTAL Due

MEMBERSHIP FEE INFORMATION :
* A one-time $50 non-refundable application fee is required with all new applications for membership.

PAYMENT METHOD:
☐ **Payment by Check**: Please make check payable to **ACIME**
☐ **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.**

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