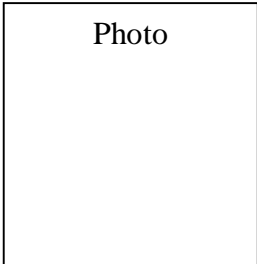




**American College of
Independent Medical
Examiners**

MEMBERSHIP APPLICATION

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): _____

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**