How to Apply: The Application Process

To apply, submit your application packet consisting of:

1. Completed Application Form
2. Payment of Annual Dues and Nonrefundable Application Fee.

Annual Dues and Fees

Payment must be enclosed with application for processing.

Cardiovascular Team Membership Annual Dues	$110
Application Fee	$25
Total Payment to Accompany Application	**$135**

Mail your entire packet to:

American College of Cardiology Resource Center
2400 N Street, NW
Washington, DC 20037

P: (202) 375-6000, ext. 5603
(800) 253-4636, ext. 5603
F: (202) 375-6842

Resource@acc.org

START APPLICATION HERE

AMERICAN COLLEGE of CARDIOLOGY

CARDIOVASCULAR TEAM APPLICATION

For Residents in the US and US Territories

Complete the application in its entirety. Please print or type ("See CV" is not acceptable)

I am applying as a:

- ❑ Clinical Nurse Specialist
- ❑ Clinical Pharmacist
- ❑ Clinical Psychologist
- ❑ Clinical Social Worker
- ❑ Exercise Physiologist
- ❑ Genetic Counselor
- ❑ Nurse Practitioner
- ❑ Occupational Therapist
- ❑ Physical Therapist
- ❑ Physician Assistant
- ❑ Registered Cardiac Electrophysiology Specialist
- ❑ Registered Cardiac Sonographer
- ❑ Registered Cardiovascular Invasive Specialist
- ❑ Registered Congenital Cardiac Sonographer
- ❑ Registered Diagnostic Cardiac Sonographer
- ❑ Registered Dietician
- ❑ Registered Nurse
- ❑ Registered Vascular Specialist
- ❑ Registered Vascular Technologist

PERSONAL DATA

Birth Date (Month/Day/Year) _____ Gender ❑ M ❑ F NPI #_____

Prefix First Name Middle Name Last Name Degrees Suffix

Race/Ethnicity

❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Native Hawaiian or Other Pacific Islander
❑ Hispanic or Latino ❑ Asian ❑ Other_____

CONTACT INFORMATION

Preferred Mailing Address

Specify type: ❑ Practice/Institution ❑ Home/Personal

Street Address City State/Province Postal Code Country

Practice/Institution Name (If applicable) Department Name (If applicable)

Preferred Phone Specify type: ❑ Practice/Institution ❑ Home/Personal Fax

Preferred Email Specify type: ❑ Practice/Institution ❑ Home/Personal

Alternate Mailing Address (Not required)

Specify type: ❑ Practice/Institution ❑ Home/Personal

Street Address City State/Province Postal Code Country

Practice/Institution Name (If applicable) Department Name (If applicable)

Alternate Phone (Not required) Specify type: ❑ Practice/Institution ❑ Home/Personal Fax

Alternate Email (Not required) Specify type: ❑ Practice/Institution ❑ Home/Personal

PAYMENT *Payment must be included with application to ensure processing*

Please enclose $135 with the application. (Payment of $110 dues + $25 application fee)

❑ MasterCard ❑ VISA ❑ American Express ❑ Discover *ACC does not accept any other credit cards* Promo Code: _____

Card # CSC # (Required) *3-digit number on back of card or 4-digit on front of Amex* Exp.Date

❑ **Check** – payable in US funds drawn on a US bank. Check #_____ Amount _____

LICENSURE *required*

Are you currently licensed to practice? ☐❑ Yes ☐❑ No

License Number	License State/Province	License Country	Date Issued	License Type

BOARD CERTIFICATION

Primary Board Certifying Body	State	Date of Initial Certification

Subspecialty Board Certifying Body	State	Date of Initial Certification

EDUCATION

Education	Institution Name	Institution City/State/Country	Degree	Year Graduated
Undergraduate College/University				
Graduate/ Medical School				

POSTGRADUATE TRAINING – **Internships, Residency, Fellowship** (If applicable)

Institution Name	Institution City/State/Country	Position/Title	Start Date	End Date

APPOINTMENTS **(Hospital and/or Academic)**

Below please indicate all appointments held, both past and present. Indicate appointment type and fill in all sections, or write "none" if that is the case. Attach separate sheet for additional appointments.

Institution Name	Institution City/State/Country	Appointment Type	Position/Title	Start Date	End Date
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			
		❑ ☐Hospital ❑ ☐Academic			

MILITARY SERVICE

Branch	Assignment	Start Date	End Date

PROFESSIONAL TIME/CLINICAL FOCUS

Indicate the **percentage of time** dedicated to the cardiovascular field _____%

Number of years in CV Practice _____

Indicate **percentage of work time** dedicated to each, totaling 100%

_____% Research _____ % Education _____ % Clinical Practice _____ % Administration _____ % Other

Rank the top three areas of clinical focus where you spend most of your professional time working in by entering 1, 2, and 3.

___ Adult Cardiology
___ Adult Congenital Cardiology
___ Anesthesiology
___ Arrhythmias and Devices
___ Cardiac Rehab
___ Cardiothoracic Surgery
___ Congenital Cardiac Surgery
___ Critical Care Medicine
___ Echocardiography
___ Electrophysiology
___ Emergency Medicine
___ Endocrinology
___ Family Practice
___ General Cardiology
___ Geriatrics/Aging and CV Disease
___ Heath Policy
___ Heart Failure/Transplant
___ Hypertension
___ Internal Medicine
___ Interventional Cardiology
___ Invasive Cardiology
___ Lipids Clinic
___ MR/CT Cardiology
___ Nephrology
___ Nuclear Cardiology
___ Nuclear Medicine
___ Pathology
___ Pediatric Cardiology
___ Pediatric Interventional Cardiology
___ Pediatrics/Neonatal
___ Pharmacology
___ Physical Medicine
___ Physiology
___ Preventive Cardiology
___ Public Health
___ Pulmonary Disease
___ Radiology
___ Sports & Exercise Cardiology
___ Thoracic Surgery
___ Transcatheter Valve Therapy
___ Vascular & Interventional Radiology
___ Vascular Medicine
___ Vascular Surgery
___ Other _____

Please sign and date your application

Signature of Applicant Date

Check before you submit! Ensure your application is completed in full and all required elements listed under "How to Apply" are included with your application.

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