AMERICAN COLLEGE of CARDIOLOGY

AFFILIATE APPLICATION

Residents in the US, US Territories and Canada.
Application must be completed in its entirety. "See CV" is not acceptable.
Additional forms can be found at *ACC.org/Join*.

PERSONAL DATA

I am applying as a: ❑ CV Veterinarian ❑ Geriatrician ❑ Emergency Professional ❑ Hospitalist

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

Prefix First Name Middle Initial Last Name Suffix

Race/Ethnicity

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

Preferred Mailing Address ❑ Work ❑ Home

Work Address

Practice/Institution Dept. Name Company URL

Hospital/Institution Address City State/Province Postal Code Country

Phone Alternate Phone Fax

Home Address

Home/Personal Address City State/Province Postal Code Country

Phone Alternate Phone Fax

Email Address Check preferred email address ❑ Business ❑ Personal

Business Email Personal Email

PAYMENT *PAYMENT MUST BE INCLUDED WITH APPLICATION*

Please include a payment of $125 with your application. ($100 annual dues plus a $25 application fee)

❑ MasterCard ❑ VISA ❑ American Express ❑ Discover *ACC does not accept any other credit cards*

Card #_____ CSC #_____ Exp. Date_____ Total Amount _____
(3-digit number on back of card or front of Amex)

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

CURRENT SOCIETY MEMBERSHIP

Are you a current member of a recognized medical/professional society? ❑ Yes ❑ No

Medical Society Name Membership Start Date

Those without a current membership in a recognized medical/professional society will need to submit a letter of sponsorship from one ACC member with their application.

LICENSURE

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

License No.	Date Issued

BOARD CERTIFICATION

Are you certified by a recognized medical specialty examining board in the US or Canada? ☐❑ Yes ☐❑ No

Name of Certifying Body _____

Certification Names and Dates Indicate which primary, subspecialty and additional Board Certifications you have

Primary Board Certification Type	Initial Cert. Date	Last Recert. Date	Subspecialty Board Certification Type	Initial Cert. Date	Last Recert. Date	Tertiary Board Certification Type	Initial Cert. Date	Last Re-cert. Date

EDUCATION

Please be as accurate and complete as possible. **Note:** If there is a break in chronology, please use a separate sheet to indicate activity/location/dates. If your medical degree was received from an institution outside the US, please send a copy of the diploma with English translation. If PhD, please provide copy of certificate.

	Name, City, State of Institution	Date Graduated	Degree
College or University			
Medical School			

POSTGRADUATE TRAINING (e.g.: Intern, Resident, Fellow)*

Name, City and State of Institution	Position or Title	Inclusive Dates

ACADEMIC APPOINTMENTS

Both past and present. Fill in all sections, or write "none" if that is the case.* Attach separate sheet for additional appointments

Name, City and State of Institution	Position or Title	Inclusive Dates

*"See CV" is not acceptable.

HOSPITAL APPOINTMENTS

Name, City and State of Institution	Position or Title	Inclusive Dates

MILITARY SERVICE

Branch and Assignment	From	To

PRACTICE SETTING

Which of the following best describes your primary work setting? (Choose one)

❑ Cardiovascular Group
❑ Government Hospital or Agency-Military
❑ Government Hospital or Agency-Other
❑ Government Hospital or Agency-Veterans Affairs
❑ Industry (pharma, device)
❑ Insurance Company (HMO, PPO, IPA)
❑ Medical School/University
❑ Multi-Specialty Group
❑ Non-governmental Hospital
❑ Retired
❑ Solo Practice
❑ Other, please specify _____

What is the ownership structure of your practice? (Choose one)

❑ Government Owned ❑ Hospital Owned ❑ Insurance Company Owned ❑ Medical School/University Owned
❑ Physician Owned ❑ Not Sure ❑ Other, please specify_____

PROFESSIONAL TIME AND SPECIALIZATION(S)

Percentage of overall professional time devoted to the cardiovascular field _____%
Of your CV professional work, rank the top three specialties you work on most by entering 1, 2 and 3.

___ Adult Congenital Cardiology
___ Cardiovascular Surgery
___ Cardiovascular Research
___ Clinical Cardiology/General Cardiology
___ CT Cardiology
___ Echocardiology/Echocardiography
___ Electrophysiology
___ MR Cardiology
___ Nuclear Cardiology
___ Pediatric Cardiology
___ Preventive Cardiology
___ Thoracic Surgery
___ Vascular Medicine
___ Other (specify) _____

AREAS OF INTEREST

Please indicate your top three areas of interest relevant to your primary clinical activities by entering 1, 2 and 3 below:

___ Administration
___ 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
___ Research
___ Sports & Exercise Cardiology
___ Thoracic Surgery
___ Transcatheter Valve Therapy
___ Vascular & Interventional Radiology
___ Vascular Medicine
___ Vascular Surgery
___ Other _____

WORK ACTIVITIES

Indicate % of work time devoted to each, totaling 100% ___% Research ___ % Education ___% Clinical Practice ___% Administration ___% Other

DISCLOSURE

1. **Has your medical license ever been suspended, terminated or reduced in scope?**
   ❑ □Yes ❑ □No If yes, please explain fully on separate page.

2. **Have you ever had hospital staff privileges denied, reduced in scope or rescinded for cause?**
   ❑ □Yes ❑ □No If yes, please explain fully on separate page.

3. **Have you ever had disciplinary action taken against you at any time by a medical society, academic institution or government agency?**
   ❑ □Yes ❑ □No If yes, please explain fully on separate page.

4. **Have you ever been convicted of, or plead guilty to, a felony or other serious crime?**
   ❑ □Yes ❑ □No If yes, please explain fully on separate page.

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I hereby consent to the release by any hospital, educational institution governmental agency, physician, professional society, or other person possessing or requiring the same, whether or not listed above, of any and all information in any way pertaining to my personal character, training, experience, or professional competence.

I agree that communications of any nature made to the College regarding my fitness for membership may be made in confidence and shall not be made available to me under any circumstances, I hereby release from any liability and all individuals and organizations or their authorized representatives who provide this information in good faith and without malice subject to this consent. I hereby release from all liability the American College of Cardiology and any and all individuals for their acts performed in good faith and without malice in connection with evaluation my application and my credentials and qualifications.

I hereby certify that all information recorded on this application and any attached document is accurate and supports my qualifications for membership in the American College of Cardiology for which I now apply. I hereby agree that the American College of Cardiology may verify any of the above data.

If elected, I agree to conform to the Bylaws of the College and its Code of Ethics. Information available to be can be found at *CardioSource.org/ethics*.

Signature of Applicant Date

Send your completed, signed application and payment to:

American College of Cardiology
ATTN: Member Services
2400 N Street, NW
Washington, DC 20037

P: (202) 375-6000, ext. 5439 | (800) 253-4636, ext. 5439
E: *membership@acc.org*