Application for ACPE Membership

Physicians eligible for membership in ACPE: MD, DO, DDS, DMD and DPM physicians who have graduated from a medical, dental or podiatric school in the U.S. or Canada, accredited by the Liaison Committee on Medical Education (LCME), or have graduated from an osteopathic college of medicine accredited by the American Osteopathic Association (AOA), or hold a Standard Certificate certification by the Educational Council for Foreign Medical Graduates (ECFMG). **Annual dues are $250,** plus a $30 processing fee. No examination is required for membership. Please return this completed application along with payment of $280 (U.S. currency) to ACPE at the address below.

Please type or print clearly or attach your primary business card.

Name ____
First Name | Middle (optional) | Last Name

❒ MD ❒ DO ❒ DDS ❒ DMD ❒ DPM ❒ Other Degrees ________________ Date of Birth: ______________ Nickname ______________

Are you a current physician member of the U.S. Public Health Service Commissioned Corps? ❒ Yes ❒ No

Primary Position and Organization Information

I currently hold the position of ____

I have held this position since ___________________________ . I devote approximately ______ % of my professional time to this position.

Organization ____

Organization Address ____

City/State/Zip/Country ____

Phone ___________________________ Fax ____________________________ Primary E-mail Address ___________________________

❒ Please send all correspondence to the above address.

❒ Preferred mailing address ____

City/State/Zip/Country ____

Primary Specialty ____ Board Certified? ❒ Yes ❒ No

Medical School ____ Year Graduated _________________
Name | City, State, or Foreign Country

Reason for joining ACPE ____

Referred by ____

To better serve our members, we ask you for the following information:

Gender: ❒ Male ❒ Female

Race or ethnicity: ❒ African-American ❒ American Indian/Alaskan Native ❒ Asian/Pacific Islander ❒ Caucasian ❒ Hispanic ❒ Other____________

In signing this application, I certify that I meet the requirements for ACPE Membership as stated above and that I have read and agree to the ACPE Code of Conduct (**www.acpe.org/conduct**) and that the information contained herein is correct. I understand that misrepresentation or omission of facts is cause for my application to be rejected or future dismissal.

Signature of Applicant ____ Date ______________________

Charge $280 to my credit card: ❒ Visa ❒ MasterCard ❒ Discover ❒ American Express ❒ Check enclosed (payable to ACPE)

Credit Card # ____ Exp. Date ______________________

Signature for credit card ____ Date ______________________

American College of Physician Executives

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