



Member Information

This membership category is for allied health professionals (nurses, ultrasonographers, ultrasound technologists & technicians, DPMs, PAs and administrators) practicing in the domestic United States and its territories. Please print clearly. This information will be used in the Online Provider Directory.

First, Mid and Last Name: _____

Designation (DPM, RN, NP, PA-C, PhD, etc.): _____

Company: _____

Street Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Personal Email (Required. This will be used as your Member Login): _____

Website: _____ Twitter: _____

Phone: _____ Fax: _____ Cell Phone: _____

Demographic Information

The specialty practiced in my office: Primary: _____ Secondary: _____

Graduate School or Other: _____ Patient Volume in venous disease: _____ %

Year you started phlebology: _____ Birth Date: _____ Gender: Male Female

Other Medical Society Affiliations (AVF, SIR, ACS, etc.) _____

I am interested in receiving information and communications from the following special interest sections:

Nursing Ultrasonography Advanced Practice Nurse/Physician Assistant Lymphedema Therapist

Payment Information

Annual Dues for ACP Membership = \$195.00

One-time Only Application Fee = +\$ 95.00

Coupons, Discounts, Certificates = -\$ _____ Coupon code: _____

Final Total Due = \$ _____

For Office Use Only Received:	Entered in DB/ID #	Make File Folder	Payment Processed	Email Confirm	Packet Sent
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Member Payment Information

Check Made Payable to: AMERICAN COLLEGE OF PHLEBOLOGY Amount: _____

Credit Card: MasterCard Visa American Express Discover Expiration Date: _____

Credit Card Number: _____ Security Code: _____

Name on Card: _____

Billing address if different from above:

Street Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Please mail, fax or email this form to the ACP offices below. You may also fill out and submit your application online at www.phlebology.org/membership/join