American College of PHLEBOLOGY

MEMBERSHIP APPLICATION
Physician MD/DO

Member Information

This membership category is for MDs and DOs currently licensed and practicing in the domestic United States and its territories. Please print clearly. This information will be used on the Online Provider Directory.

First, Mid and Last Name: _____

Designation (MD, DO, FACPh 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

Current Specialty: Primary: _____ Secondary: _____

Type of Practice (Private, hospital, etc.): _____ Patient volume in venous disease: _____ %

Medical School: _____ Grad Year: _____ License #: _____

Residency Specialty: _____ Year you started phlebology: _____

Birth Date: _____ AMA #: _____ Gender: ☐ Male ☐ Female

I was referred to the ACP by:

Colleague: _____ Education Meeting: _____ Other: _____

Payment Information

Annual Dues for ACP Membership	=	$550.00
One-time Only Application Fee	=	+$ 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

Member Physician 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.html