AMERICAN COLLEGE OF GASTROENTEROLOGY

6400 Goldsboro Road, Suite 200, Bethesda, Maryland 20817-5842

Telephone: 301-263-9000, Fax: 301-263-9025

ALLIED HEALTH PROFESSIONAL MEMBERSHIP APPLICATION

QUALIFICATIONS FOR ALLIED HEALTH PROFESSIONAL MEMBERSHIP

- The applicant for Allied Health Professional Membership must be working with an ACG Physician Member.
- The applicant must possess one of the following certifications: RN, APRN, CGRN, LPN or be involved in GI clinical care (practice manager or genetic counselor).

CONTACT INFORMATION

First Name: ________________ Middle Initial: ________ Last Name: ________________

Date of Birth: ________________ NPI Number *(required for U.S. allied health professionals only)*: ________________

Current Degree: ❑ RN ❑ APRN ❑ CGRN ❑ LPN ❑ Practice Manager ❑ Genetic Counselor ❑ Other: ________________

Position/Title: ________________

Practice/Institution: ________________

Address: ________________

City: ________________ State: ________________ Zip/Postal Code: ________________ Country: ________________

E-mail: ________________

Phone *(Int'l include country and city codes for all numbers)*: ________________ Fax: ________________

Home Address: ________________

City: ________________ State: ________________ Zip/Postal Code: ________________ Country: ________________

Phone: ________________ **Please mail materials to my:** ❑ Work Address ❑ Home Address

EDUCATION

University: ________________ Degree: ________________ Date Awarded: ________________

University: ________________ Degree: ________________ Date Awarded: ________________

ADVANCED TRAINING / CERTIFICATION *(if applicable)*

Institution: ________________ Degree/Certification: ________________ Inclusive Dates: ________________

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MEMBERSHIP IN OTHER PROFESSIONAL SOCIETIES

Society: ________________ Date Joined: ________________

Society: ________________ Date Joined: ________________

Society: ________________ Date Joined: ________________

Society: ________________ Date Joined: ________________

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JOB STATUS

My Current Position is: ❑ Full-time ❑ Part-time

REASONS FOR JOINING THE SOCIETY *(check all that apply)*

- ❑ Education
- ❑ Complimentary Registration to Annual Meeting
- ❑ Subscription to the *American Journal of Gastroenterology*
- ❑ Access to ACG website member's only section
- ❑ Professional
- ❑ Other: ______________________________

DEMOGRAPHICS *(Optional)*

Gender: ❑ Male ❑ Female

Practice Setting:
(check all that apply)

❑ Private Practice**:**
- ❑ Solo Practice
- ❑ Practice with 5 or fewer MDs
- ❑ Practice with 6 or more MDs
- ❑ Multi-specialty group

❑ Academic

❑ Non-Practice Setting / Other

Area of Interests:
(check all that apply)

❑ Biliary	❑ Colon	❑ Endoscopy	❑ Esophagus	❑ Functional Bowel Disease
❑ Geriatrics	❑ IBD	❑ Liver / Hepatology	❑ Motility	❑ Oncology
❑ Outcomes Studies	❑ Pancreas / Small Bowel	❑ Pediatrics	❑ Stomach	

PROPOSER INFORMATION *(Required)*

Your Proposer must be an ACG Physician Member.

Proposer's Name: ______________________________ ❑ ACG Member ❑ ACG Fellow

Proposer's Phone Number: __________________ E-mail: ______________________________

Signature of Proposer: ____

PAYMENT INFORMATION

Application Fee: $150 *(Payment must be submitted with application in U.S. Dollars only.)*

❑ My check made payable to the ACG is enclosed. ❑ My credit card information is below.

❑ Visa ❑ Mastercard ❑ American Express

Credit Card Number:______________________________ Exp. Date: __________ 3 or 4 Digit Security Code: ______________

Name on card:______________________________ Signature: ______________________________