



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 (mm/dd/yyyy): _____

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: _____

Institution: _____ Degree/Certification: _____ Inclusive Dates: _____

Institution: _____ Degree/Certification: _____ Inclusive Dates: _____

MEMBERSHIP IN OTHER PROFESSIONAL SOCIETIES

Society: _____ Date Joined: _____

Society: _____ Date Joined: _____

Society: _____ Date Joined: _____

Society: _____ Date Joined: _____

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: Private Practice: Academic Non-Practice Setting / Other
(check all that apply)

- Solo Practice
- Practice with 5 or fewer physicians
- Practice with 6 - 10 physicians
- Practice with 11 or more physicians
- Multi-specialty group

Areas of Interest / Specialty: Biliary Colon Endoscopy Esophagus Functional General GI
(check all that apply) Geriatrics IBD Liver / Hepatology Motility Oncology Outcomes Studies
 Pancreas Pediatrics Small Bowel 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: _____