



2016 Membership Application

PLEASE PRINT OR TYPE

Name: Degree:

Address:

City: State: Zip: Country:

Phone:Home: (.....) Office: (.....) FAX :(.....)

Email: Website:

Professional Affiliations:

Place of Practice or Employment Address:

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Professional Member – MD, DO,DC, PhD	\$ 100.00	International	<input type="checkbox"/>
General Member – Certified Thermographer	\$ 100.00	International	<input type="checkbox"/>
Affiliated Member – All others	\$ 75.00	International	<input type="checkbox"/>
Resident/Student Member	\$ 50.00	International	<input type="checkbox"/>

Area of Study:

Amount Enclosed \$

Please include a copy of your current license and proof of insurance if applicable. For students, enclose a copy of current Student ID.

PLEASE COMPLETE QUESTIONNAIRE ON BACK BEFORE SIGNING BELOW

I have read and understand the American College of Clinical Thermology Practice Guidelines, Being the ACCT Constitution, the Code of Ethics, the Code of Practice and ACCT Policy Statements and I agree to uphold and abide by them. I also state that I have completed the questionnaire truthfully and to the best of my ability.

Signature: Date:/...../.....

Questionnaire must be completed in full before signing on front. Please print or type.

Please check all that apply

- Have had my license revoked for any reason
- Have lost hospital privileges
- Have been asked to leave other professional organizations
- Have any current legal actions or pending actions against me
- Have you ever been arrested for a felony
- Have you had any Drug or Alcohol convictions

If you checked any of the above please provide details below:

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Are you a US Citizen YES NO

Please list any specialties, research, publications or particular areas of interest:

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Please submit this form with your check payable to:

American College of Clinical Thermology, Inc.
3717 Boston St #378
Baltimore, MD 21224

Phone: 1-866-281-5479

www.thermologyonline.org