

MEMBER APPLICATION

THIS FORM MUST BE TYPED OR PRINTED

The American Academy of Cardiovascular Perfusion



MR. MISS

NAME MS. MRS.

(LAST)

(FIRST)

(MIDDLE)

DATE OF BIRTH

(MONTH - DAY - YEAR)

BUSINESS ADDRESS

(ORGANIZATION)

(YOUR TITLE)

(STREET ADDRESS)

(ADDITIONAL ADDRESS)

(CITY)

(STATE)

(ZIP CODE)

(COUNTRY)

(TELEPHONE NUMBER)

(FAX NUMBER)

(E-MAIL)

HOME ADDRESS

(STREET ADDRESS)

(CITY)

(STATE)

(ZIP CODE)

(COUNTRY)

(TELEPHONE NUMBER)

(FAX NUMBER)

(E-MAIL)

EDUCATION

COLLEGE / UNIVERSITY

DATES ATTENDED

DEGREE

MAJOR

1)

2)

PERFUSION SCHOOL

1)

CURRENT ACTIVE PROFESSIONAL MEMBERSHIP

ORGANIZATION

MEMBER SINCE

POSITION(S) HELD

1)

2)

3)

DID YOU GRADUATE FROM AN ACCREDITED PERFUSION SCHOOL?

YES

NO

ARE YOU CURRENTLY ACTIVE AS A FULL TIME PERFUSIONIST?

YES

NO

NUMBER OF YEARS PRACTICING PERFUSION? _____

YEARS

HAVE YOU ATTENDED AN ANNUAL ACADEMY MEETING?

YES

NO

HAVE YOU PARTICIPATED IN AN ANNUAL ACADEMY MEETING?

YES

NO

IF YES, CHECK ALL THAT APPLY: PRESENTER ATTENDEE PANEL MEMBER OTHER

PREFERRED MAILING ADDRESS BUSINESS ADDRESS HOME ADDRESS

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT.

(DATE)

(APPLICANT'S SIGNATURE)

AACP 10-08

APPLICATION AND FILING FEE OF \$25.00 WITH FIRST YEAR DUES OF \$145.00 (U.S. FUNDS) TOTAL \$170.00

VIA CHECK OR MONEY ORDER TO:

AACP

515A EAST MAIN STREET

ANNVILLE, PA 17003

VIA VISA / MasterCard CREDIT CARD:

Card Number _____

Expiration Date _____

You may FAX completed form to (717) 867-1485, or mail to the national office.