

STUDENT 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)

I AM CURRENTLY A PERFUSION STUDENT APPLYING FOR STUDENT ASSOCIATE MEMBERSHIP __ YES __ NO

EDUCATION

PERFUSION SCHOOL _____ EXPECTED GRADUATION DATE _____

1) _____

COLLEGE / UNIVERSITY _____ DATES ATTENDED _____ DEGREE _____ MAJOR _____

1) _____

2) _____

CURRENT ACTIVE PROFESSIONAL MEMBERSHIP

ORGANIZATION _____ MEMBER SINCE _____ POSITION(S) HELD _____

1) _____

2) _____

3) _____

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 UNDERSTAND THAT I AM TO ATTACH A LETTER FROM MY PERFUSION SCHOOL DIRECTOR.

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

(DATE)

(APPLICANT'S SIGNATURE)

AACP 02-08

SUBMIT COMPLETED APPLICATION AND FIRST YEAR DUES OF \$25.00 (U.S. FUNDS) TOTAL \$25.00

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 and letter to (717) 867-1485, or mail to the national office.