



ALLIED HEALTH
PROFESSIONALS

JOIN ACAAI

ADVANCE YOUR
CAREER

ACAAI American College
of Allergy, Asthma
& Immunology

Follow the Leader Into the Future

EMPLOYMENT

Employer _____

Position _____ Dates of Employment _____

Previous Allergy/Immunology Related Employment _____

How much of your time do you spend with Allergic/Asthmatic Patients?

All More than 50% Between 25-50% Occasional

Have you ever been the subject of any disciplinary action by a Medical Licensing Body? Yes No

Have you ever had your Hospital Privileges suspended or revoked? Yes No

If you answered "Yes" to either of the above questions, please provide an explanation in an accompanying letter.

MEMBERSHIPS

Please list current memberships in allergy/immunology societies and other major medical or nursing societies.

List the allergy/immunology meetings, dates & locations attended during the past three years.

Publications: (Provide exact titles and references & enclose reprints, if available.)

Applications must be sponsored by an ACAAI Fellow or Member and accompanied by a letter of recommendation.

Signature of Sponsor _____

Address of Sponsor _____

Name and address of one additional physician for reference (Physician in your community who knows you)

1. _____

I hereby certify that all information recorded on the application and any attached documents are accurate and support my qualifications for associate/allied membership.

Date _____ Signature of Applicant _____

PAYMENT METHOD

Submit the \$25 application fee with your completed application to: ACAAI Membership, 85 West Algonquin Rd., Suite 550, Arlington Hts, IL 60005 or FAX to 847-427-1294.

My check payable to ACAAI is enclosed

Please charge my application fee to my credit card (circle one) MasterCard Visa American Express

Card Number _____ Expiration Date _____

Signature _____

MEMBERSHIP BENEFITS AND APPLICATION PROCEDURES

MEMBERSHIP CLASSIFICATIONS

Associate Members. A registered nurse (R.N.), nurse practitioner (N.P.), clinical nurse specialist, or certified physicians assistant (P.A.) engaged in allergy/immunology.

Allied Members. A physician in a related field, a licensed practical nurse (L.P.N.), licensed visiting nurse (L.V.N.) or other non-physician engaged in a technical or administrative position in allergy/immunology.

MEMBERSHIP BENEFITS

- On-line access to the *Annals of Allergy, Asthma and Immunology*
- Reduced registration fees for the ACAAI Annual Convention
- Special Allied Health, Asthma Educator, Office Administrator and Clinical Research Coordinator Programs at the ACAAI Annual Convention
- Subscription to *AllergyWatch*, a bimonthly review of recent literature related to allergy/immunology
- ACAAI eNews, an informative biweekly email newsletter
- Subscription to the printed ACAAI Newsletter
- Listing in the ACAAI Membership Directory

ANNUAL DUES

- A \$25 non-refundable application fee must be submitted with your application.
- Annual dues are \$65 (invoiced after your application is approved).

GUIDELINES FOR COMPLETING THE APPLICATION

- Type or print clearly. Illegible applications will be returned.
- Check the category for which you are applying (Associate or Allied).
- Complete all sections of the application. If a section does not apply, please enter N/A.
- Have your sponsor (a physician Member or Fellow of ACAAI) sign the application.
- Include a letter of recommendation from your sponsor with your application.
- Provide the name and address of one additional physician for reference.
- Sign and date the application.
- Enclose the required \$25 application fee.
- Mail or FAX the application to ACAAI by the deadline (April 15 or October 1).

ACAAI MEMBER/FELLOW SPONSOR

- Your sponsor must be a physician Member or Fellow of ACAAI. If you do not know an ACAAI Member/Fellow, contact the Membership Department at 847-427-1200 for a list of members in your area. Your sponsor must sign the application and submit a letter of recommendation. Your application will not be considered unless a letter is received.
- The sponsor's recommendation should be on letterhead stationary and include the type of work performed by the applicant, and his/her character and ethical standing.
- The applicant shall provide one additional physician's name and address for reference. He/she does not need to be a Member or Fellow of the College. The College will mail him/her a form to complete and return. Your application will not be considered until this form is received.

APPLICATION REVIEW PROCESS

Upon receipt of your completed application (all questions answered, sponsorship letters and \$25 application fee received) it will be forwarded to the Credentials Committee for review and recommendation. Your application will then be considered by the Board of Regents.

Membership applications are considered by the Board of Regents at its Spring and Fall meetings.

The American College of Allergy, Asthma and Immunology is a leading organization of physicians and allied health professionals who diagnose and treat asthma and allergic diseases. Membership is open to all allied health professionals who have an interest in the field, and seek to advance their career.

Membership applications are considered semiannually and must be received prior to April 15 or October 1.

ASSOCIATE/ALLIED MEMBERSHIP APPLICATION

The American College of Allergy, Asthma and Immunology
85 W. Algonquin Rd., Suite 550
Arlington Heights, IL 60005-4460
(847) 427-1200 • Fax (847) 427-1294

Date Received _____

ID # _____

For ACAAI Office Use

Please print or type I am applying for Associate ____ Allied ____ membership.

Name _____
(first) (middle) (last)

RN ____ NP ____ PA ____ MD ____ LPN ____ LVN ____ Med. Assistant ____ Other ____

License# and State _____ Date _____

Citizenship _____ Place of Birth _____ Date of Birth _____ Sex: M ____ F ____

Social Security# _____ Spouse's Name _____

Office Address _____

City _____ State _____ Zip _____ Country _____

Office Phone (____) _____ Fax (____) _____ Email _____

While your home address and phone number will be retained on file, they will **NOT** be published.

Home Address _____

City _____ State _____ Zip _____ Country _____

Home Phone (____) _____ Fax (____) _____ Email _____

I wish to have my mail sent to (check one) Home Address ____ Office Address ____

EDUCATION & TRAINING

Degrees	Area of Study	Name of College or University (Undergraduate)	Location (City)	From	To
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Degrees/ Courses	Area of Study	Name of University (Graduate)	Location (City)	From	To
#1 _____	_____	_____	_____	_____	_____
#2 _____	_____	_____	_____	_____	_____
#3 _____	_____	_____	_____	_____	_____

Enclose separate sheet, if necessary

Current Certification _____

CURRENT TEACHING AND HOSPITAL AFFILIATIONS

1. Institution _____

Title _____

2. Institution _____

Title _____

Please be specific. An incomplete or unsigned application will not be processed.