**Print and submit this application or join online NOW!** Join online now ▶

ACCM
ACADEMY OF CERTIFIED CASE MANAGERS

# Membership Application

You must use DOD/VA address to be eligible.

❑ I wish to become a member. Date _____

First Name Middle Name Last Name

Home Address

City State Zip

Telephone Fax DOD/VA address e-mail (required)

Certification ID #_____ *(ACCM mailings will be sent to home address)*

## Practice Setting:

*Which best describes your practice setting?*

❑ Independent/Case Management Company
❑ Rehabilitation Facility
❑ Medical Group/IPA
❑ Hospice
❑ Consultant
❑ HMO/PPO/MCO/InsuranceCompany/TPA
❑ Hospital
❑ Home Care/Infusion
❑ Academic Institution
❑ VA
❑ DOD/Military
❑ Other: _____

# JOIN ACCM TODAY!

❑ 1 year: ~~$120~~ **$100** (Year begins at time of joining.)

❑ Check or money order enclosed made payable to: **Academy of Certified Case Managers.**
Mail check along with a copy of application to:
**Academy of Certified Case Managers, 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990.**

❑ MasterCard ❑ Visa ❑ American Express

If using a credit card, you may mail to the address above, or fax the application to: **203-547-7273.**

Card # _____ Exp. Date:_____ Security Code:_____

Name on Credit Card:_____ Signature: _____

Credit Card Billing Address: _____

City:_____ State:_____ Zip:_____

For office use only:_____ Membership #_____ Membership expiration_____