

Application for Professional Membership

▶ YOUR INFORMATION

Name and Degree

Office Address

City, State, Zip

Office Phone

Office Fax

Office URL (i.e. www.yourpracticename.com)

E-mail (required, will not be shared or posted)

▶ AREAS OF PRACTICE

Will be listed on your profile -- while we do not limit these, choosing too many can crowd your profile.
We recommend ten (10) or less

- | | |
|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Legal Medicine |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Anti-Aging | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Mesotherapy |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Metabolic Medicine |
| <input type="checkbox"/> Acupressure | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Obstetrics |
| <input type="checkbox"/> Auriculotherapy | <input type="checkbox"/> Orthomolecular Medicine |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Auto-immune Diseases | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Bariatrics | <input type="checkbox"/> Oriental Medicine |
| <input type="checkbox"/> Botanical Medicine | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Osteopathic Manipulation |
| <input type="checkbox"/> Chelation Therapy | <input type="checkbox"/> Otolaryngology |
| <input type="checkbox"/> Chest Disease | <input type="checkbox"/> Oxidative Medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Ozone Therapy |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Colon Hydrotherapy | <input type="checkbox"/> Parkinsons Disease |
| <input type="checkbox"/> Cosmetic Laser Surgery | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Degenerative Disease | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Dentistry (Holistic) | <input type="checkbox"/> Predictive Genomic Testing |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Preventive Medicine |
| <input type="checkbox"/> Detoxification | <input type="checkbox"/> Physical Medicine & Rehab |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Dioxichlor Treatment | <input type="checkbox"/> Psychiatry (Orthomolecular) |
| <input type="checkbox"/> EECF | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Electrodermal Screening | <input type="checkbox"/> Prolotherapy |
| <input type="checkbox"/> Electromagnetic Therapy | <input type="checkbox"/> Photoluminescence Therapy |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Environmental Medicine | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Reflexology |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Fasting | <input type="checkbox"/> Rhinology |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Functional Medicine | <input type="checkbox"/> Sexual Health |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Stem Cell Therapy |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Glutathione | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Gynecology | <input type="checkbox"/> Thermography |
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Herbology | <input type="checkbox"/> Ultraviolet Therapy |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Hyperbaric Oxygen | <input type="checkbox"/> Voice Medicine |
| <input type="checkbox"/> Hydrogen Peroxide Therapy | <input type="checkbox"/> Weight Reduction |
| <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Hormone Replacement Therapy | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Yeast Syndrome |
| <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Holistic Medicine |
| <input type="checkbox"/> Insulin Potentiated Therapy | <input type="checkbox"/> Naturopathic Medicine |
| <input type="checkbox"/> Internal Medicine | |
| <input type="checkbox"/> IV Therapies | |

Membership Type:

New Membership

Renewal Membership

Professional MD/DO Member
\$475 US / \$375 Non-US

Professional ND Member
\$390 US / \$290 Non-US

Affiliate Member
\$390 US / \$290 Non-US

Associate Member
\$295 US / \$195 Non-US

Retired Member
\$295 US / \$195 Non-US

Student / Resident Member - no charge
What school / residency?

Est. date of completion: _____

How did you hear about us? (New members)

Friend / Colleague Google Advertisement Other

▶ Manage your profile online at www.acam.org

Select a username and we will e-mail you a temporary password.
You can add a photo, custom message to potential patients and more when you sign-in.

Desired username:

▶ Send in a copy of your license and CV

Fax these items to: 949-272-3729

Your membership will not be activated until we receive these items

▶ Dues Payment

We accept American Express, Visa, MasterCard, Discover and JCB
Checks may be processed as an electronic debit, make checks payable to ACAM

Card Number: _____

Expiration: _____ CVV: _____

▶ Agree to terms:

I hereby apply for membership in the American College for Advancement in Medicine and agree to abide by its bylaws, vision, mission, strategic goals, code of ethics. I have no charges pending from any state licensing board, and I am not under investigation for unethical or incompetent practices by any professional, hospital, or state organization, nor have I ever been convicted of a felony. I give ACAM permission to contact medical schools, references and other entities for the purpose of verifying information provided in this application. I understand ACAM has the right to audit memberships for accuracy and validity.

Signature: _____

Date: _____