



ACADEMY OF CERTIFIED CASE MANAGERS

Membership Application

Do not use this application after December 31, 2011.

I wish to become a member.

Date

First Name Middle Name Last Name

Home Address

City State Zip

Telephone Fax e-mail

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
- Other: _____

JOIN ACCM TODAY!

1 year: \$120 (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, PO Box 210, Green's Farms, CT 06838-0210.

MasterCard Visa American Express If using a credit card you may fax application to: **203-227-9495**

Card # _____ Exp. Date: _____

Person's Name on Credit Card: _____ Signature: _____

Credit Card Billing Address: _____

City: _____ State: _____ Zip: _____

For office use only: _____ Membership # _____ Membership expiration _____

join/renew ACCM online at www.joinACCM.org