



ACADEMY OF CERTIFIED CASE MANAGERS

Membership Application

Do not use this application after June 30, 2010.

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

HMO/PPO/MCO/InsuranceCompany/TPA

Rehabilitation Facility

Hospital

Medical Group/IPA

Home Care/Infusion

Hospice

Academic Institution

Consultant

Other: _____

JOIN ACCM TODAY!

1 year: \$115

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

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