Association of Critical Care Transport (ACCT)

2019 REGULAR 12-MONTH MEMBERSHIP APPLICATION

Please submit your completed and signed membership application to Fax# (816) 858-6177 or mail to Association of Critical Care Transport, PO Box 170, Platte City, MO 64079 or email to mcoons@medserv.us. For any questions regarding the membership application, please contact Melissa Coons at (816) 858-6175 or mcoons@medserv.us or ACCT Executive Director Roxanne Shanks at rshanks@acctforpatients.org.

Membership Information

Name of Organization: ______________________________

Street/Mailing Address: ______________________________

City, State, Zip: ______________________________

Primary Contact: ______________________________ Title: ______________________________

Email: ______________________________ Website: ______________________________

Work Phone #: ______________________________ Cell Phone #: ______________________________

Program Information and Dues

Regular 12-Month Membership (air and/or ground transport program) is $660. The application must be approved by the Board of Directors. Please see the ACCT Membership Benefits and Dues information at www.acctforpatients.org for detailed information.

Please provide the following information:

	# of units staffed 12-24 hours/day
Helicopters	
Fixed Wing Aircraft	
Ground Critical Care and/or Specialty Transport	

Please provide a list of make and model of aircraft owned or operated by your organization.

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Please provide a list of the make and model of critical care ground vehicles owned or operated by your organization:

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Dues Payment Information

Payment Methods

Payment options for Regular Member Annual Dues (please check one):

- ☐ Credit Card (a processing fee may apply)
- ☐ Payment Enclosed; Check #_________
  (Payable to Association of Critical Care Transport, PO Box 170, Platte City, MO 64079)
- ☐ Request for Invoice

Credit Card payment	**Credit Card Billing Address (if different from above):**
☐Visa ☐MasterCard ☐American Express ☐Discover	Name on card: ______________________
Card #: ______________________	Address:______________________
Expiration Date (month/year): ______________	City:____________State:________Zip:______
Authorizing Signature:	Country:____________Phone:____________
______________________	Email:______________________

Invoice: Name and address where invoice should be sent if different than the primary contact listed on page one.

Name: ____

Street/Mailing Address: ______________________________________

City, State, Zip:____

Phone: ______________________ Email: ______________________

Participation in ACCT

Areas of Interest for Specific Involvement for Primary Contact:

- ☐ Finance and Development Committee
- ☐ Communications Committee
- ☐ Standards/Quality Metrics Committee
- ☐ Education Committee
- ☐ Governance Committee
- ☐ Policy Committee

Please answer the following:

1. Are you an FAA part 135 certificate holder? ☐Yes ☐No
2. How many of your RW are:
   - ☐ Affiliated with a hospital or healthcare system? ______________________
   - ☐ Community-based? ______________________

General Support of ACCT Vision, Mission, Values and Platform

Your signature at the end of the application form is an affirmation of your general agreement to support the Vision, Mission, Values and Platform (outlined on the website www.acctforpatients.org) of ACCT.

I,_________________________________ (print name) generally support the Vision, Mission, Values and Platform as outlined above, of the Association of Critical Care Transport (ACCT).

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Signature **Date**