Association of Critical Care Transport (ACCT)

2018 REGULAR MEMBERSHIP APPLICATION

Please submit your completed and signed membership application form to Fax# (816) 858-6177 or mail to Association of Critical Care Transport, PO Box 170, Platte City, MO 64079, e-mail 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

Please see the ACCT Membership Benefits and Dues information at www.acctforpatients.org for detailed information.

Regular Membership (air and/or ground transport program) yearly dues are calculated as follows (with a cap of $33,000 per year).

- ☐ $1,000 membership fee plus vehicle fees below (total fees capped at $33,000)
- ☐ Amount per Helicopter: $850
- ☐ Amount per Fixed Wing Aircraft: $575
- ☐ Amount per Ground Critical Care Vehicle: $300

Example: (One program with $1000 membership fee and 1 helicopter, 1 fixed wing and 1 critical care ground = $2,725)

For regular membership, please provide the following information to assess dues:

	Fee	# of units staffed 12-24 hours/day	Total Dues Amount
Helicopters	$850		
Fixed Wing Aircraft	$575		
Ground Critical Care and/or Specialty Transport	$300		
Total Regular Member Dues:		**$1000 + $_____ = $_____**	

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

_____

_____

_____

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

_____

_____

_____

Dues Payment Information

Payment Methods

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

- ☐ Credit Card
- ☐ 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

Areas of Interest for Specific Involvement for Other Individuals in Your Organization:
Please provide contact information and interest areas for other individuals in your organization who will be participating in ACCT:

Name/Title:_____ Work Phone: _____

Email:_____ Cell: _____

Areas of Interest:

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

Name/Title:_____ Work Phone: _____

Email:_____ Cell: _____

Areas of Interest:

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

Name/Title:_____ Work Phone: _____

Email:_____ Cell: _____

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).

_____

Signature **Date**