



**Association of Critical Care Transport (ACCT)**  
**2019 AFFILIATE 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](mailto:mcoons@medserv.us). For any questions regarding the membership application, please contact Melissa Coons at (816) 858-6175, or [mcoons@medserv.us](mailto:mcoons@medserv.us), or ACCT Executive Director Roxanne Shanks at [rshanks@acctforpatients.org](mailto: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**

**Affiliate Membership is \$660 per year. Please see the ACCT Membership Benefits and Dues information at [www.acctforpatients.org](http://www.acctforpatients.org) for detailed information.**

**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:

**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: \_\_\_\_\_

**Dues Payment Information**

**Payment Methods**

Payment options for Associate 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**

- Visa
- American Express
- MasterCard
- Discover

Card #: \_\_\_\_\_

Expiration Date (month/year): \_\_\_\_\_

Authorizing Signature: \_\_\_\_\_

**Credit Card Billing Address (if different from above):**

Name on card: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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: \_\_\_\_\_

**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](http://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