



Association of Critical Care Transport (ACCT) 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 Peek at rpeek@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).

- \$1,100 membership fee plus vehicle fees below (total fees capped at \$33,000)
- Amount per Helicopter: \$875
- Amount per Fixed Wing Aircraft: \$595
- Amount per Ground Critical Care Vehicle: \$310

Example: (One program with \$1,100 membership fee and 1 helicopter, 1 fixed wing and 1 critical care ground = \$2,880)

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

	Fee	# of units staffed 12-24 hours/day	Total Dues Amount
Helicopters	\$875		
Fixed Wing Aircraft	\$595		
Ground Critical Care and/or Specialty Transport	\$310		
Total Regular Member Dues:		\$1100 + \$ _____ = \$ _____	

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 (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

<p>Credit Card payment</p> <p><input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover</p> <p>Card #: _____</p> <p>Expiration Date (month/year): _____</p> <p>Authorizing Signature: _____</p>	<p>Credit Card Billing Address (if different from above):</p> <p>Name on card: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Country: _____ Phone: _____</p> <p>Email: _____</p>
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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:

- | | |
|--|---|
| <input type="checkbox"/> Finance and Development Committee | <input type="checkbox"/> Governance Committee |
| <input type="checkbox"/> Communications Committee | <input type="checkbox"/> Policy Committee |
| <input type="checkbox"/> Standards/Quality Metrics Committee | |
| <input type="checkbox"/> Education 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: _____

Areas of Interest:

- 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).

Signature

Date