ACCM
ACADEMY OF CERTIFIED CASE MANAGERS

Membership Application

Do not use this application after June 30, 2017.

❑ I wish to become a member.

Date

First Name | Middle Name | Last Name

Home Address

City | State | Zip

Telephone | Fax | e-mail (required)

Certification ID #_____ *(ACCM mailings will be sent to home address)*

Practice Setting:

Which best describes your practice setting?

❑ Independent/Case Management Company
❑ Rehabilitation Facility
❑ Medical Group/IPA
❑ Hospice
❑ Consultant
❑ HMO/PPO/MCO/InsuranceCompany/TPA
❑ Hospital
❑ Home Care/Infusion
❑ Academic Institution
❑ Other: _____

JOIN ACCM TODAY!

❑ 1 year: $120 (year begins at time of joining)

❑ 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, 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990.

❑ MasterCard ❑ Visa ❑ American Express If using a credit card you may fax application to: 203-547-7273

Card # _____ Exp. Date:_____ Security Code: _____

Person's Name on Credit Card: _____Signature: _____

Credit Card Billing Address: _____

City:_____ State: _____ Zip:_____

join/renew ACCM online at **www.academyCCM.org**

For office use only:_____Membership #_____ Membership expiration_____