MEMBERSHIP APPLICATION

ACRM AMERICAN CONGRESS OF REHABILITATION MEDICINE

Improving lives through interdisciplinary rehabilitation research

❍ Dr. ❍ Ms. ❍ Mr. ❍ Mrs. Referred by ______

First Name ______ Last Name ______

Credentials ______ Title ______

(Please include designations as you would like them to appear. EX: PhD, MS, OTR/L)

Nickname ______

HOME

❍ *Check if HOME is your primary contact*

Address 1 ______

Address 2 ______

City ______ St/Province ______

Zip/Postal Code ______ Country ______

Tel ______ Mobile ______

Email ______

WORK

❍ *Check if WORK is your primary contact*

Organization ______

Department ______

Work Address 1 ______

Work Address 2 ______

City ______ St/Province ______

Zip/Postal Code ______ Country ______

Tel ______ Mobile ______

Email ______

COMMUNICATION PREFERENCES

I prefer to receive email: *(please check one)* ❍ AT HOME ❍ AT WORK

I prefer to receive regular mail: *(please check one)* ❍ AT HOME ❍ AT WORK

❍ I wish to *not* be listed in the ACRM member directory

SPECIALIZATIONS *(Check all that apply)*

- ❍ Bioengineering
- ❍ Biostatistics | Clinical Research
- ❍ Case Manager
- ❍ Clinical Epidemiology
- ❍ Counseling, Pastoral
- ❍ Counseling, Rehabilitation
- ❍ Counseling, Vocational
- ❍ Dietetics | Nutrition
- ❍ Licensed Practical Nurse
- ❍ Neurology | Neurosurgery
- ❍ Neuropsychology
- ❍ Occupational Therapy
- ❍ Pediatrics
- ❍ Physician
- ❍ Psychology
- ❍ Physiatry
- ❍ Physical Therapy
- ❍ Psychiatry
- ❍ Recreation Therapy
- ❍ Rehabilitation Nursing
- ❍ Rehabilitation Psychology
- ❍ Social Work
- ❍ Speech | Language Pathology
- ❍ Other *(Please specify):* ______

WORK FUNCTION *(Choose one)*

- ❍ Administrator
- ❍ Clinician
- ❍ Consultant
- ❍ Educator
- ❍ Payer
- ❍ Program Evaluator
- ❍ Researcher
- ❍ Student
- ❍ Other ______

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CATEGORIES & DUES *(Choose one)*

❍ **REGULAR** **$ 350**
For professionals in medical rehabilitation or related field and are actively engaged in the practice, administration, education or research of medical rehabilitation.

❍ **INTERNATIONAL** **$ 350**
REGULAR status residing outside the U.S.

❍ **CONSUMER** **$ 150**
For people with disabilities and caregivers who use rehabilitation services and/or research.

❍ **EARLY CAREER** **$ 150**
For professionals during the first five years after completion of post-graduate studies.
Completion Date (mo/yr) ______________________

❍ **STUDENT, RESIDENT OR FELLOW** **$ 85**
Enrolled in an accredited school of medicine or approved graduate or undergraduate program or fellowship in a medical rehabilitation discipline. Proof required.

Graduation Date (mo/year) ______________________

Personal/home email address ______________________

Training Director (name, credentials and email)

____

____

Membership Dues $ __________

Donations *(Unspecified)* $ __________

ACRM Walk-a-thon Donation $ __________

Wilkerson Fund Donation $ __________

Promo Code ____________ **Total** $ __________

INTERDISCIPLINARY SPECIAL INTEREST & NETWORKING GROUPS

ACRM members are welcome and encouraged to join any and all interdisciplinary special interest groups (ISIGs) and networking groups. Please select all groups in which you wish to participate:

- ❍ Brain Injury Interdisciplinary Special Interest Group (BI-ISIG)
- ❍ Spinal Cord Injury Interdisciplinary Special Interest Group (SCI-ISIG)
- ❍ Stroke Interdisciplinary Special Interest Group (STROKE-ISIG)
- ❍ Cancer Rehabilitation Networking Group
- ❍ Complementary Integrative Rehabilitation Medicine Networking Group
- ❍ Early Career Networking Group
- ❍ Geriatric Rehabilitation Networking Group
- ❍ Health Services Research Networking Group
- ❍ International Networking Group
- ❍ Measurement Networking Group
- ❍ Military / Veterans Affairs Networking Group
- ❍ Neurodegenerative Diseases Networking Group
- ❍ Neuroplasticity Networking Group
- ❍ Pediatric Rehabilitation Networking Group
- ❍ Physicians & Clinicians Networking Group
- ❍ Technology Networking Group
- ❍ Arts & Neuroscience Networking Group
- ❍ Limb Restoration Rehabilitation Group
- ❍ Pain Rehabilitation Group

PAYMENT OPTIONS *(Payment accepted in U.S. dollars only)*

Check payable to **ACRM**
Mail to: P.O. Box 896700, Charlotte, NC 28289-6700

Credit Card Fax to: +1.866.692.1619
Email to: MemberServices@ACRM.org
Email address ______________________________
TO SEND PAYMENT CONFIRMATION

❍ VISA ❍ MasterCard ❍ Amex ❍ Discover

Card # ______________________________

Exp ________________ Security Code __________

Signature ______________________________

Print Name ______________________________

BILLING ADDRESS

☐ Check if same as mailing address on pg 1

Address 1 ______________________________

Address 2 ______________________________

City ______________________________

State / Province ______________________________

Zip / Postal Code ______________________________

Country ______________________________