MEMBERSHIP APPLICATION

ACRM 90+ YEARS SINCE 1923

ACRM AMERICAN CONGRESS OF REHABILITATION MEDICINE

Improving lives through interdisciplinary rehabilitation research

☐ Dr. ☐ Ms. ☐ Mr. ☐ Mrs. Referred by _____

First Name _____ Last Name _____

Credentials _____

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

HOME

Address 1 _____

Address 2 _____

City _____ St/Province _____

Zip/Postal Code _____ Country _____

Tel _____ Mobile _____

Email _____

WORK

Organization _____

Title _____

Department _____

Work Address 1 _____

Work Address 2 _____

City _____ St/Province _____

Zip/Postal Code _____ Country _____

Tel _____ Mobile _____

Email _____

COMMUNICATION PREFERENCE *(check one)*

I prefer to receive email: ☐ AT HOME ☐ AT WORK

I prefer to receive regular mail: ☐ 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 _____

MEMBERSHIP APPLICATION

ACRM 90+ YEARS SINCE 1923

ACRM AMERICAN CONGRESS OF REHABILITATION MEDICINE

Improving lives through interdisciplinary rehabilitation research

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** — **$ 350**
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) _____
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
- ☐ Early Career Networking Group
- ☐ Geriatric Rehabilitation Networking Group
- ☐ Health Policy Networking Group
- ☐ International Networking Group
- ☐ Military / Veterans Affairs Networking Group
- ☐ Neurodegenerative Diseases Networking Group
- ☐ Measurement Networking Group
- ☐ Pain Rehabilitation Group
- ☐ Pediatric Rehabilitation Networking Group
- ☐ Neuroplasticity Networking Group

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

Check payable to **ACRM**
Mail to: PO Box 759272, Baltimore, MD 21275-9272

Credit Card
Fax to: +1.866.692.1619
Email to: MemberServices@ACRM.org

VISA MasterCard Amex Discover

Card # _____

Exp _____ Security Code _____

Signature _____

Email address to send payment confirmation _____

SUBMIT

EMAIL: MemberServices@ACRM.org
OR
FAX: +1.866.692.1619
OR
MAIL: PO BOX 759272, Baltimore MD 21275-9272

BILLING ADDRESS

☐ Check if same as mailing address on pg 1

Address 1 _____
Address 2 _____
City _____
State / Province _____
Zip / Postal Code _____
Country _____