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 _____ 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** $ $ 0.00

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: PO Box 759272, Baltimore, MD 21275-9272

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 _____