Association of Critical Care Transport (ACCT)

2019 INTERNATIONAL MEMBERSHIP APPLICATION

Please submit your completed and signed membership application to Fax# (816) 858-6177 or mail to Association of Critical Care Transport, PO Box 170, Platte City, MO 64079, or email 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 Shanks at rshanks@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

International Membership is $1,195 per year. Please see the ACCT Membership Benefits and Dues information at www.acctforpatients.org for detailed information.

Please provide the following information:

<table>
<thead>
<tr>
<th># of units staffed</th>
<th>12-24 hours/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helicopters</td>
<td></td>
</tr>
<tr>
<td>Fixed Wing Aircraft</td>
<td></td>
</tr>
<tr>
<td>Ground Critical Care and/or Specialty Transport</td>
<td></td>
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</tbody>
</table>

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:

______________________________________________________________________________
______________________________________________________________________________
Participation in ACCT

Areas of Interest for Specific Involvement for Primary Contact:
- Finance and Development Committee
- Communications Committee
- Standards/Quality Metrics Committee
- Education Committee
- Governance Committee
- Policy 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:

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: _______________________________

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? _______________________________
Dues Payment Information

Payment Methods
Payment options for International 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

Credit Card payment

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card #: ________________________________
Expiration Date (month/year): ________________
Authorizing Signature: __________________________

Credit Card Billing Address (if different from above):

Name on card: ________________________________
Address: ___________________________________
City: __________________ State: _______ Zip: ______
Country: _______________ Phone: ______________
Email: ________________________________

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: __________________

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