Association of Critical Care Transport (ACCT)
2019 REGULAR 12-MONTH 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
Regular 12-Month Membership (air and/or ground transport program) is $660. The application must be approved by the Board of Directors. 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>Aircraft Type</th>
<th># of units staffed 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>
</tr>
</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:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
### Dues Payment Information

#### Payment Methods
Payment options for Regular 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

<table>
<thead>
<tr>
<th>Credit Card payment</th>
<th>Credit Card Billing Address (if different from above):</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Visa  [ ] MasterCard  [ ] American Express  [ ] Discover</td>
<td>Name on card: __________________________________________</td>
</tr>
<tr>
<td>Card #: __________________________</td>
<td>Address: ______________________________________________</td>
</tr>
<tr>
<td>Expiration Date (month/year): ______________________</td>
<td>City: __________________________ State: ______ Zip: ______</td>
</tr>
<tr>
<td>Authorizing Signature: ____________________________________________</td>
<td>Country: ________________ Phone: ________________________</td>
</tr>
<tr>
<td></td>
<td>Email: ________________________________________________</td>
</tr>
</tbody>
</table>

#### 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: __________________________

### 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

#### 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? __________________________

### 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](http://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