



American
College
of Allergy, Asthma
& Immunology



Allied Health Professionals

Join the
American College
of Allergy, Asthma
and Immunology

**Advance
Your Career**

Membership Benefits and Application Procedures

The American College of Allergy, Asthma and Immunology is a leading organization of physicians and allied health professionals who diagnose and treat asthma and allergic diseases. Membership is open to all allied health professionals who have an interest in the field, and seek to advance their career.



Membership Classification.

Allied Members. To qualify as an Allied Member, an applicant shall be a registered nurse (RN), nurse practitioner, clinical nurse specialist, certified physician's assistant (PA), a licensed practical nurse or other non-physician engaged in a technical or administrative position in allergy/immunology, shall be sponsored by an ACAAI Fellow/Member and shall meet such other criteria as may be established from time to time by the Board of Regents.

Membership Benefits.

- Online access to the *Annals of Allergy, Asthma and Immunology*.
- Reduced registration fees for the ACAAI Annual Convention.
- Subscription to *AllergyWatch*, a bimonthly review of recent literature related to allergy/immunology.
- ACAAI eNews, an informative email newsletter.
- Subscription to the printed ACAAI newsletter.
- Listing in the ACAAI Membership Directory.

Guidelines for Completing the Application.

- Type or print clearly. Illegible applications will be returned.
- Complete all sections of the application. If a section does not apply, please enter N/A.
- Include a letter of recommendation from your sponsor with your application.
- Include a copy of your Curriculum Vitae/Resumé.
- Sign and date the application.
- Enclose the required \$25 application fee.
- Mail, fax, or email the application to ACAAI.

ACAAI Member/Fellow Sponsor.

- Your sponsor must be a physician Member or Fellow of ACAAI. If you do not know an ACAAI Member/Fellow, contact the Membership Department at 847-427-1200 for a list of members in your area. Your sponsor must submit a letter of recommendation. Your application will not be considered unless a letter is received.
- The sponsor's recommendation should be on letterhead stationary and include the type of work performed by the applicant, and his/her character and ethical standing.



Application Review Process.

Upon receipt of your completed application (all questions answered, sponsorship letter and \$25 application fee received) it will be forwarded to the Credentials Committee for review and recommendation. Your application will then be considered by the Board of Regents. Membership applications are considered by the Board of Regents at its Spring and Fall meetings.

Allied Membership Application



The American College of Allergy, Asthma and Immunology
85 W. Algonquin Road, Suite 550 | Arlington Heights, IL 60005
Phone (847) 427-1200 | Fax (847) 427-1294 | www.acaai.org

FOR OFFICE USE ONLY

Amt. Rcvd. _____

Date Rcvd. _____

ID No. _____

Please print or type:

NAME, FIRST								MIDDLE	LAST		GENDER	
RN	NP	PA	MD	LPN	LVN	MEDICAL ASSISTANT	OTHER	MALE	FEMALE			

CREDENTIALS

NPI # (U.S. only) _____ STATE LICENSE # _____ STATE _____

DATE OF BIRTH _____ SPOUSE'S FIRST NAME _____ INSTITUTION _____

OFFICE ADDRESS

CITY _____ STATE _____ ZIP _____ COUNTRY _____

OFFICE PHONE _____ OFFICE FAX _____

OFFICE EMAIL _____ OFFICE WEBSITE _____

While your home address and phone number will be retained on file, they will **NOT** be published.

HOME ADDRESS

CITY _____ STATE _____ ZIP _____ COUNTRY _____

HOME PHONE _____ HOME FAX _____

HOME ADDRESS _____ OFFICE ADDRESS _____

HOME EMAIL _____ PREFERRED MAILING/BILLING ADDRESS (Please choose only one) _____

EDUCATION AND TRAINING:

DEGREE	AREA OF STUDY	COLLEGE OR UNIVERSITY
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LOCATION (CITY)	BEGIN YEAR	END YEAR
-----------------	------------	----------

DEGREE	AREA OF STUDY	COLLEGE OR UNIVERSITY
--------	---------------	-----------------------

LOCATION (CITY)	BEGIN YEAR	END YEAR
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CURRENT CERTIFICATION

CURRENT TEACHING AFFILIATIONS:

INSTITUTION	TITLE
-------------	-------

INSTITUTION	TITLE
-------------	-------

EMPLOYMENT

EMPLOYER

POSITION	DATES OF EMPLOYMENT
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PREVIOUS ALLERGY/IMMUNOLOGY-RELATED EMPLOYMENT

How much of your time do you spend with Allergic/Asthmatic Patients? 100% More than 50% Between 25-50% Occasional

Have you been the subject of any disciplinary action by a medical licensure body? No Yes

Have you had your hospital privileges suspended, revoked or modified? No Yes

If you answered "Yes" to either of the above questions, please provide an explanation in an accompanying letter.

MEMBERSHIPS:

Please list current memberships in allergy/immunology societies and other major medical or nursing societies.

List the allergy/immunology meetings, dates and locations attended during the past three years.

Please include a copy of your Curriculum Vitae.

Applications must be sponsored by an ACAAI Fellow or Member and accompanied by a letter of recommendation.

I hereby certify that: (1) I have read and will abide by the precepts of the College's bylaws; and (2) All information recorded on the application and any attached documents is accurate and supports my qualifications for allied membership in ACAAI for which I now apply.

DATE

SIGNATURE OF APPLICANT

PLEASE NOTE: An incomplete application or an application missing reference letters will not be processed.

APPLICATION FEE PAYMENT METHOD:

Check Enclosed

MasterCard

VISA

American Express

Submit the \$25 application fee with your completed application to:

ACAAI Membership, 85 West Algonquin Road, Suite 550, Arlington Heights, IL 60005 or fax to 847-427-1294 or email to membership@acaaai.org.

CARD NUMBER

EXPIRATION DATE

SECURITY CODE

SIGNATURE



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