ASSOCIATION OF CHILDREN’S PROSTHETIC-ORTHOTIC CLINICS
121 W State St • Geneva, IL 60134
e-mail: acpoc@affinity-strategies.com ~ website: www.acpoc.org

MEMBERSHIP APPLICATION

MEMBERSHIP CATEGORY: DATE: ____________________________
PHYSICIAN - $275 first-year’s dues plus $25 application fee
NON-PHYSICIAN - $165 first-year’s dues plus $25 application fee
CORRESPONDING MEMBER - $110 first-year’s dues plus $25 application fee

NAME: __________________________________________________________________________
(Last)       (First)       (Middle)

Professional designation:
☐ M.D.  ☐ O.T.  ☐ C.P.O.  ☐ Ph.D.
☐ C.P.   ☐ P.T.  ☐ C.O.    ☐ D.O.
☐ R.N.   ☐ S.W.  ☐ M.S.    ☐ Other: _______________________

Percentage of children treated in your practice (non-exhibit applicants only): ___________________________

What are your expectations in becoming a member of ACPOC?:
________________________________________________________________________________________
________________________________________________________________________________________

Office Address: (Affiliated with an ACPOC Clinic):

Clinic: __________________________________________________________________________________
Street Address: ___________________________________________________________________________
City, State, Postal Code: ______________________________________ Country: ______________________
Clinic Phone: __________________________ Clinic Fax: ________________________________
Email: ____________________________________________ Clinic Chief: ___________________________
Website: ________________________________________________________________________________

Office Address: (applicants not affiliated with an ACPOC Clinic): (private practice, exhibitor, technician, etc.)
Company/Institute: ________________________________________________________________________
Street Address: __________________________________________________________________________
City, State, Postal Code: ______________________________________ Country: ______________________
Office Phone: __________________________ Office Fax: ________________________________
E-mail: __________________________
Best Mailing Address  Company/Institute/Home: ________________________________
(If different from page one)
City, State, Postal Code: _____________________________ Country: ______________________
Office Phone: _____________________________ Office Fax: ____________________________
E-mail: ____________________________________________________________________________

CLINIC LISTING: (Optional)

(Please Check One) □ NEW CLINIC  □ EXISTING CLINIC  □ AFFILIATED WITH A CLINIC

Clinic Name: ________________________________________________________________
Street Address: ________________________________________________________________
City, State, Postal Code: _____________________________ Country: ______________________
Clinic Phone: _____________________________ Clinic Fax: ____________________________
Email: ____________________________________________________________________________
Website: __________________________________________________________________________
Clinic Administrative Contact: _______________________________________________________
Clinic Chief: _____________________________ Health Profession: ________________________
Team Member: _____________________________ Health Profession: ________________________
Team Member: _____________________________ Health Profession: ________________________

Minimum Requirements to be listed as a clinic:

One designated Clinic Chief and two Team Members, all must be ACPOC members in good standing.
Clinics must include management of children with orthopaedic, orthotic and/or prosthetic problems.
Referred by: ________________________________________________________________________
(Optional)

Signature: __________________________________________________ Date: ________________

FCC REGULATIONS

I am authorized to and hereby consent to receiving information from the ACPOC via fax about ACPOC
products, programs, and services. I understand that this information will be sent by or on behalf of the
Association of Children’s Prosthetic-Orthotic Clinics.
I understand that if I fail to meet my payment obligations to ACPOC, my membership will lapse.

Signature: __________________________________________________ Fax: ______________________

If you wish to pay by check, please return completed form with full payment to:

Association of Children’s Prosthetic-Orthotic Clinics
121 W State St
Geneva, IL  60134
NAME: ________________________________________________________

ACPOC MEMBER PROFILE QUESTIONNAIRE

An important membership benefit is the web site and access to a members only page. Initial access requires confirmation of active membership, followed by setting of your access password. An important goal of the members only page is to facilitate communication between members. Therefore at the initial sign in, each member will also be asked to fill out a short survey. This information will allow sorting of members for networking opportunities. Please make sure your membership is active (paid by June 1st) for continued access.

1. Please indicate any other professional organizations that you are an active member? (choose all that apply)
   - AACPDM
   - AAOP
   - ASHA
   - AAOS
   - AAP
   - AAPMR
   - ACA
   - AOPA
   - AOTA
   - APTA
   - CAOT
   - CAPO
   - CPA
   - CSRS
   - DDNA
   - EPOS
   - ISPO
   - MSTS
   - Nursing Assn.
   - OPC
   - POSNA
   - SRS
   - Other ______________________

2. Years of practice with pediatric population?  □ 0-2  □ 3-5  □ 6-10  □ 10 or greater.

3. Percentage of pediatric (0-18) population in total practice?  □ 10%  □ 25%  □ 50%  □ 50-75%  □ 75-100%  □ 100%

4. What diagnoses do you treat? (check all that apply)
   - arthrogryposis
   - cerebral palsy
   - clubfoot
   - congenital limb deficiency
   - LE amputation
   - LE limb length discrepancy
   - muscular dystrophy
   - ortho. oncology
   - plagiocephaly
   - spinal cord injury
   - scoliosis
   - spina bifida
   - UE amputation
   - UE limb length discrepancy
   - Other ______________________

5. Do you have an area of expertise, experience, or certification?
   - assistive technology
   - cerebral Palsy
   - clubfoot
   - congenital limb deficiency
   - gait analysis
   - LE orthotics
   - LE prosthetics
   - myoelectrics
   - ortho. oncology
   - product design
   - rehabilitation
   - spinal deformities
   - sports/recreation/camps
   - UE orthotics (including low temperature splinting)
   - UE prosthetics
   - Other ______________________

6. Do we have your permission to publish your profile in the Members Only area of the ACPOC web site, so that other ACPOC members can see your information? □ YES  □ NO

7. Are you interested in being listed as an expert contact for the public in your specialty area?  □ YES  □ NO

8. How many ACPOC annual conferences have you attended in the last five years?  □ 0  □ 1  □ 2  □ 3  □ 4  □ 5

9. Do you consider yourself to be active in the ACPOC organization? □ YES  □ NO

10. Would you like to be contacted to know how you can become more active in ACPOC? □ YES  □ NO