

# ASSOCIATION OF CHILDREN'S PROSTHETIC-ORTHOTIC CLINICS

PO BOX 62 • Fennville, MI 49408

e-mail: [acpoclinics@gmail.com](mailto:acpoclinics@gmail.com) ~ website: [www.acpoc.org](http://www.acpoc.org)

## MEMBERSHIP APPLICATION

MEMBERSHIP CATEGORY:

DATE: \_\_\_\_\_

**PHYSICIAN - \$285 first-year's dues plus \$25 application fee**

**NON-PHYSICIAN - \$175 first-year's dues plus \$25 application fee**

**CORRESPONDING MEMBER - \$120 first-year's dues plus \$25 application fee**

**STUDENT MEMBER - \$35 three year's dues plus \$25 application fee**

**CLINIC MEMBER - Discounted rate on Physician, Non-Physician and**

**Corresponding membership if you have 3+ people who want to join and belong to the same clinic/hospital**

NAME: \_\_\_\_\_

(Last)

(First)

(Middle)

Professional designation:

|                          |      |                          |      |                          |        |                          |              |
|--------------------------|------|--------------------------|------|--------------------------|--------|--------------------------|--------------|
| <input type="checkbox"/> | M.D. | <input type="checkbox"/> | O.T. | <input type="checkbox"/> | C.P.O. | <input type="checkbox"/> | Ph.D.        |
| <input type="checkbox"/> | C.P. | <input type="checkbox"/> | P.T. | <input type="checkbox"/> | C.O.   | <input type="checkbox"/> | D.O.         |
| <input type="checkbox"/> | R.N. | <input type="checkbox"/> | S.W. | <input type="checkbox"/> | M.S.   | <input type="checkbox"/> | Other: _____ |

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

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

\_\_\_\_\_  
\_\_\_\_\_

**Office/School or Residency Program 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: \_\_\_\_\_

**Student Membership**

Please email [acpoclinics@gmail.com](mailto:acpoclinics@gmail.com) proof of enrollment in school or program required with graduation dates, upload a letter from your director when you apply.

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

Association of Children's Prosthetic-Orthotic Clinics  
PO BOX 62  
Fennville, MI 49408

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 1<sup>st</sup>) 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)  

|   |   |
|---|---|
| <input type="checkbox"/> arthrogyrosis              | <input type="checkbox"/> plagiocephaly              |
| <input type="checkbox"/> cerebral palsy             | <input type="checkbox"/> spinal cord injury         |
| <input type="checkbox"/> clubfoot                   | <input type="checkbox"/> scoliosis                  |
| <input type="checkbox"/> congenital limb deficiency | <input type="checkbox"/> spina bifida               |
| <input type="checkbox"/> LE amputation              | <input type="checkbox"/> UE amputation              |
| <input type="checkbox"/> LE limb length discrepancy | <input type="checkbox"/> UE limb length discrepancy |
| <input type="checkbox"/> muscular dystrophy         | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> ortho. oncology            |   |
5. Do you have an area of expertise, experience, or certification?  

|   |   |
|---|---|
| <input type="checkbox"/> assistive technology       | <input type="checkbox"/> product design                                     |
| <input type="checkbox"/> cerebral Palsy             | <input type="checkbox"/> rehabilitation                                     |
| <input type="checkbox"/> clubfoot                   | <input type="checkbox"/> spinal deformities                                 |
| <input type="checkbox"/> congenital limb deficiency | <input type="checkbox"/> sports/recreation/camps                            |
| <input type="checkbox"/> gait analysis              | <input type="checkbox"/> UE orthotics (including low temperature splinting) |
| <input type="checkbox"/> LE orthotics               | <input type="checkbox"/> UE prosthetics                                     |
| <input type="checkbox"/> LE prosthetics             | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> myoelectrics               |   |
| <input type="checkbox"/> ortho. oncology            |   |
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

