



American College of Legal Medicine Application for Membership

I. Membership Categories

I am applying for:

- FELLOW** (\$100 member application fee*, \$325 annual dues)
A professional with either an MD, DO, or DDS degree AND a JD degree, all degrees from accredited schools, and licensed to practice in either profession.
- INTERNATIONAL FELLOW** (\$100 member application fee*, \$295 annual dues)
An applicant who resides permanently in a country other than the United States or Canada, and who has both a Medical Degree, Doctor of Osteopathy, or Dental Degree AND a Law Degree, or their equivalents, is teaching or practicing medicine, osteopathy, dentistry or law in accordance with applicable laws or governmental regulations along with documentation to verify that the applicant is lawfully permitted to practice or teach Medicine, Dentistry, Osteopathy or Law in the country of residence.
- MEMBER** (\$100 member application fee*, \$215 annual dues)
A physician, attorney, dentist, nurse, health science professional or other person with recognized medical-legal expertise and the appropriate degree from an accredited school.
- INTERNATIONAL MEMBER** (\$100 member application fee*, \$195 annual dues)
A medicolegal professional residing outside the U.S. or Canada.
- STUDENT** (No application fee, \$25 annual dues)
A full-time student in an accredited professional medical, dental or law school.

II. Applicant Contact Information

*\$100 Application Fee is non-refundable.

Name _____ Date of Birth _____ Gender Male Female
 Preferred Mailing Address Office Home Credentials _____
 Office Address _____
 City _____ State/Province _____ ZIP code _____
 Country _____ Telephone _____ Fax _____
 Home Address _____
 City _____ State/Province _____ ZIP code _____
 Country _____ Telephone _____ Fax _____
 Website URL _____ Email _____
 Referred by _____

Membership Directory

- Yes, please include me in the membership directory
- No, do not include me in the membership directory

If accepted for membership, I hereby agree to abide by the Constitution and Bylaws of the American College of Legal Medicine.

Signature of Applicant _____

Date _____

III. Sponsorship

The following ACLM Member will serve as sponsor of my application:

Please send the enclosed sponsor form directly to your sponsor.

Sponsor Name: _____

NOTE: All applicants except students must provide one sponsor. If you do not know a member of the College who might serve as your sponsor, contact ACLM at (847) 752-5355 or email info@aclm.org for names of members in your area.

IV. Education

Undergraduate Training

Institution _____ City _____ Dates _____

Postgraduate Training *(exclusive of medicine and law)*

Institution _____ City _____ Dates _____

Medical or Dental *(approved schools only)*

Institution _____ City _____ Dates _____

Internship

Institution _____ City _____ Dates _____

Postgraduate and Residency

Institution _____ City _____ Dates _____

Legal *(approved schools only)*

Institution _____ City _____ Dates _____

Postgraduate Legal

Institution _____ City _____ Dates _____

Nursing

Institution _____ City _____ Dates _____

V. Licensure

Medical

License # _____ State/Province _____ Date _____

Nursing

License # _____ State/Province _____ Date _____

Legal

License # _____ State/Province _____ Date _____

Dental

License # _____ State/Province _____ Date _____

Other

License # _____ State/Province _____ Date _____

VI. Certification

If certified by a specialty examining board in a specialty or sub-specialty, please list name of each certifying board, category, and date of certification.

Certifying Board _____ Category _____ Date _____

Certifying Board _____ Category _____ Date _____

Certifying Board _____ Category _____ Date _____

Certifying Board _____ Category _____ Date _____

VII. Medical, Dental, or Legal Society/Association Memberships

Please indicate those societies of which you are a member.

Membership in one of these organizations is required for fellowship.

- American Bar Association
Date Joined _____ Offices Held (if any) _____
- American Dental Association
Date Joined _____ Offices Held (if any) _____
- American Medical Association
Date Joined _____ Offices Held (if any) _____
- American Osteopathic Association
Date Joined _____ Offices Held (if any) _____

Please list any other state or county associations or Canadian equivalents of the above of which you are a member.

- Name of Association _____
Date Joined _____ Offices Held (if any) _____
- Name of Association _____
Date Joined _____ Offices Held (if any) _____
- Name of Association _____
Date Joined _____ Offices Held (if any) _____

VIII. Hospital Appointments

Please list name of institution, your title, and inclusive dates.

Institution _____	Title _____	Dates _____
Institution _____	Title _____	Dates _____
Institution _____	Title _____	Dates _____
Institution _____	Title _____	Dates _____

IX. Academic Appointments

Please list name of institution, your title, and inclusive dates.

Institution _____	Title _____	Dates _____
Institution _____	Title _____	Dates _____
Institution _____	Title _____	Dates _____

X. Public Service

Do you devote full-time to governmental or other public service, teaching, postgraduate study or any type of institutional position without any individual private practice?

- Yes
- No

The requirement for a State license is waived while physicians are on active duty with one of the military services.

XI. Publications

Please list titles of articles or books, name of journal or publisher and date of publication.

Attach additional sheets if necessary.

Title _____	Journal/Publisher _____	Dates _____
Title _____	Journal/Publisher _____	Dates _____
Title _____	Journal/Publisher _____	Dates _____

XII. Supplemental Documents

Please be sure to enclose the following with your application:

- Copy of your valid legal, medical, dental, or health care license from at least one state
NOTE: If you are applying for fellowship status, you must include proof of licensure in one profession, and proof of degree in the other.
- Annual dues, including non-refundable application fee.
Note: Do not send credit card information by email. Use fax or mail only.)
- If you are applying for student membership, include proof of current full-time matriculation in an accredited law, medical, dental, or health care school (letter from the registrar, copy of current transcript, etc.)
- Send sponsor form to your designated sponsor. Your file will not be considered complete until sponsor form is received.

XIII. Payment Options

- Check payable to the American College of Legal Medicine
- Credit Card *select one* Visa Mastercard AmEx
- Card Number _____ Exp. Date _____ CVV # _____
- Name on Card _____ Signature: _____

Please forward application and supporting documents to:

American College of Legal Medicine

Membership Department
1061 E. Main Street, Suite 300
East Dundee, IL 60118
Phone: (847) 752-5355
Email: info@aclm.org



American College of Legal Medicine

Application for Membership

Sponsorship Request

Candidate Name _____
Credentials _____
Address _____
City _____ State/Province _____ ZIP code _____
Phone _____ Fax _____ Fax _____
Email _____

Dear ACLM Fellow Member:

The above referenced individual has applied for membership in the following category (*candidate, check one*):

- Fellow
- International Fellow
- Member
- Student
- International

in the American College of Legal Medicine and has requested that you serve as a sponsor. Read the following statement, indicate your agreement by signing this letter, and then return this letter to the ACLM office.

"I agree to sponsor the above mentioned individual for membership in the American College of Legal Medicine. I believe this individual would be a valuable addition to our organization. I know nothing that would call into question the individual's integrity, reputation, or competence in legal medicine."

Print name: _____ Date: _____
Signature: _____

Return completed form by mail or email to:

ACLM

Attn: Jodeen Burke
1061 E. Main Street, Suite 300
East Dundee, IL 60118
Email: info@aclm.org