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 permanentlly 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 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
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
Email: info@aclm.org