AMERICAN COLLEGE OF CLINICAL ENGINEERING

MEMBERSHIP APPLICATION COMPLEMENT FORM

Please complete this page for each representative who is applying for *ASSOCIATE* Membership.

Name: _____

Specialty: _____

Degree(s): _____

Professional Certification or Registration: _____

BUSINESS ADDRESS:

Employer: _____

Title: _____

Department: _____

Street: _____

City, State, Zip: _____ Country _____

Phone: _____ Fax: _____

Business E-mail address: _____

HOME ADDRESS:

Street: _____

City, State, Zip: _____ Country _____

Phone: _____ Fax: _____

Home E-mail address: _____

Preferred Destination for Correspondence & Newsletter:

☐ Business Address ☐ Home Address ☐ Business E-mail ☐ Home E-mail

☐ I am applying for **Associate Member**

Required → ☐ I am committed to the mission of this organization.

Our Mission:

- To establish a standard of competence and to promote excellence in clinical engineering practice.
- To promote safe and effective application of science and technology in patient care.
- To define the body of knowledge on which the profession is based.
- To represent the professional interests of clinical engineers.

I hereby state that this application is correct to the best of my knowledge:

Signature: _____ Date: _____