



**CLINIC LISTING: (Optional)**

(Please Circle One)      NEW CLINIC      EXISTING CLINIC      AFFILIATED WITH A CLINIC

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Email: \_\_\_\_\_

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.

Signature \_\_\_\_\_ Fax Number \_\_\_\_\_

*If you wish to pay by credit card, please fill out information here (VISA or MasterCard ONLY):*

Card Number: \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on card: \_\_\_\_\_ Signature: \_\_\_\_\_

**Please return completed form with full payment to:  
ACPOC Membership Chair  
6300 N. River Rd, Ste 727  
Rosemont, IL 60018-4226  
Phone: (847)698-1637 FAX: (847)823-0536**

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  CBCPO  CPA  CSRS  DDNA  
 EPOS  ISPO  MSTs  Nursing Assn.  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)  arthrogyrosis  

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

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