ASSOCIATION OF CHILDREN'S PROSTHETIC-ORTHOTIC CLINICS
9400 West Higgins Road, Suite 500 • Rosemont, IL 60018-4976
Phone: 847-698-1637 ~ Fax: 847-268-9560
e-mail: acpoc@aaos.org ~ website: www.acpoc.org

MEMBERSHIP APPLICATION

MEMBERSHIP CATEGORY: **DATE:** _____

PHYSICIAN - $275 first-year's dues plus $25 application fee

NON-PHYSICIAN - $165 first-year's dues plus $25 application fee

CORRESPONDING MEMBER - $110 first-year's dues plus $25 application fee

NAME: _____
(Last) (First) (Middle)

Professional designation:

☐	M.D.	☐	O.T.	☐	C.P.O.	☐	Ph.D.
☐	C.P.	☐	P.T.	☐	C.O.	☐	D.O.
☐	R.N.	☐	S.W.	☐	M.S.	☐	Other: _____

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

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

_____

_____

Office 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: _____

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.

I understand that if I fail to meet my payment obligations to ACPOC, my membership will lapse.

Signature: _____ Fax :_____

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

Association of Children's Prosthetic-Orthotic Clinics
9400 West Higgins Road, Suite 500
Rosemont, IL 60018-4976

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 1st) 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)
   ☐ arthrogryposis
   ☐ cerebral palsy
   ☐ clubfoot
   ☐ congenital limb deficiency
   ☐ LE amputation
   ☐ LE limb length discrepancy
   ☐ muscular dystrophy
   ☐ ortho. oncology
   ☐ plagiocephaly
   ☐ spinal cord injury
   ☐ scoliosis
   ☐ spina bifida
   ☐ UE amputation
   ☐ UE limb length discrepancy
   ☐ Other _____

5. Do you have an area of expertise, experience, or certification?
   ☐ assistive technology
   ☐ cerebral Palsy
   ☐ clubfoot
   ☐ congenital limb deficiency
   ☐ gait analysis
   ☐ LE orthotics
   ☐ LE prosthetics
   ☐ myoelectrics
   ☐ ortho. oncology
   ☐ product design
   ☐ rehabiliation
   ☐ spinal deformities
   ☐ sports/recreation/camps
   ☐ UE orthotics (including low temperature splinting)
   ☐ UE prosthetics
   ☐ Other _____

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