



**Ada Canyon Medical Education Consortium**  
**MEMBERSHIP APPLICATION/UPDATE FORM**

Please type all information except signatures. Handwritten applications will not be accepted.

GENERAL INFORMATION		
<b>Name:</b>	<b>Degree:</b>	<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>Practice Office Name:</b>		<b>Practice Office Address:</b>
<b>Office Phone:</b>	<b>City</b>	<b>Zip:</b>
<b>Applicant Email**:</b>		<b>Office Fax:</b>
<b>Office Manager Name:</b>		<b>Office Manager Email:</b>
<b>Satellite Practice Name:</b>		<b>Satellite Address:</b>
<b>Satellite Phone:</b>	<b>City</b>	<b>Zip:</b>
<b>Satellite Email:</b>		<b>Satellite Fax:</b>
<b>Home Address:</b>		<b>City</b> <b>Zip:</b>
<b>Home Phone:</b>		<b>Mobile Phone:</b>
<b>Home Email:</b>		<b>Home Fax:</b>
<b>Date of Birth:</b>	<b>Spouse Name:</b>	<b>Is Spouse Physician:</b> Yes <input type="checkbox"/>

EDUCATION/PROFESSIONAL PRACTICE INFORMATION		
<b>Medical Education:</b>		<b>Graduation Year:</b>
<b>Internship:</b>		<b>Graduation Year:</b>
<b>Residency:</b>		<b>Graduation Year:</b>
<b>Fellowship(s):</b>		
<b>Board Certifications:</b>		<b>Expiration Date:</b>
<b>Idaho License Number:</b>	<b>Issue Date:</b>	<b>Expiration Date:</b>
<b>Primary Specialty (AMA Specialties Only):</b>		
<b>Secondary Specialty (AMA Specialties Only):</b>		

**Applicant Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Applicant Signature:** \_\_\_\_\_

**Please make all checks payable to *Ada Canyon Medical Education Consortium* and remit \$75 membership fee to:**  
 ACMEC  
 305 W. Jefferson Street | Boise, ID 83702