

**DO NOT USE. CONTACT CAROL PRENDERGAST AT, CPRENDERGAST@SCCM.ORG
TO FIND OUT IF YOU QUALIFY.**

**MEMBERSHIP APPLICATION
FOR
FELLOW OF THE AMERICAN COLLEGE
OF CRITICAL CARE MEDICINE (FCCM)**

1. Name: Last _____ First _____ Middle _____
2. SCCM Membership: Month _____ Year _____ I.D. No. _____
3. Academic Degrees: Bachelor _____ University _____
Masters _____ University _____
Doctorate _____ University _____
Medical _____ University _____
4. Licensure: State/Province _____ # _____ Expiration _____
5. Male _____ Female _____ Date of Birth _____
6. Year Primary Board Certification was received _____ Board _____
7. a. Year Certificate of Special Competence in Critical Care was received _____ Board _____
b. Year CCRN or equivalent Certification was received _____
c. Year RRT was received _____
d. Equivalent credentials - please attach full explanation _____
8. Percent of professional time presently spent in critical care _____% (must be at least 50% to be eligible for Fellowship)

Representative breakdown of critical care activity per week must equal 100%
 - a. Direct patient care _____
 - b. Consulting _____
 - c. Teaching _____
 - d. Research _____
 - e. Writing _____
 - f. Editing _____
 - g. Lecturing _____
 - h. Administration _____
 - i. Other _____
9. Years of Training:
 - a) Residency: From _____ To _____ Institution _____
 - b) Fellowship: From _____ To _____ Institution _____
 - c) Critical Care Fellowship Training Program (specialty board) _____
From: _____ To _____ Institution _____
10. Year entered critical care practice _____
11. Name [incl. Title(s)] _____
Academic Title _____ Institution _____
Primary Position _____ Department _____
Institution/Office _____

Institution/Office Address _____

City _____ State _____ Country _____

Zip/Mail Code _____ Phone () _____ Fax () _____

e-mail: _____

12. Have you ever applied for Fellowship of the American College of Critical Care Medicine? _____

If so, what year(s) _____

AUTHORIZATION: ☒ THIS APPLICATION IS NOT VALID WITHOUT SIGNATURE AND DATE!

I hereby consent to the disclosure, inspection and copying of information and documents related to my qualifications for College Fellowship by and between the College and healthcare organizations, medical societies, professional associations, medical schools and faculty, training programs, and businesses and individuals acting as their agents for the purpose of evaluating this application regarding my qualifications for College Fellowship.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities, for their acts and/or communications made in good faith in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including the College, the Society of Critical Care Medicine, their representatives and all persons and entities providing information to the College or the Society, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for College Fellowship, including any decision to admit or deny Fellowship in the College.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my qualifications for College Fellowship. I hereby affirm that the information submitted in this application and any addenda thereto, including my curriculum vitae is true, current, correct and completed to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application and/or termination of my Society membership. I agree to provide the College with any updated information in the event of any change in the information set forth in my application.

Applicant Signature _____ **Date** _____

APPLICATION SUBMISSION DEADLINE: March 15, 2012

**→ IMPORTANT ←
APPLICANT'S CHECKLIST**

Please be sure to include the following:

- Completed application, **signed**
- Completed curriculum vitae
- Personal statement describing critical care activities, **signed**
- Current copy of confirmation of Special Competence in Critical Care (if applicable)
- Current copy of license
- Additional supporting documentation (if applicable)
- Two letters of endorsement (one from an active member of the College)
- Two forms of documentation of professional time devoted to critical care
- All documents must be translated into English
- If payment is by check, please submit a check in the amount of \$250.00 with a copy of the Membership Application to: Society of Critical Care Medicine, 35083 Eagle Way, Chicago, Illinois 60678-1350 USA.**

If payment is by credit card, please complete credit card information below.

- Visa**
- AMEX**
- Master Card**

Expiration Date _____

Credit Card No. _____

Signature _____

DRAFT