

**ACADEMY OF CORRECTIONAL HEALTH PROFESSIONALS
MEMBERSHIP RENEWAL**

Rev. 06/10

NAME AND PROFESSIONAL STATUS

Name: _____ Job title: _____

Work setting: _____ Gender: _____ Professional Training: _____

Place of employment: _____

CONTACT INFORMATION

Business Address: _____

Home Address: _____

PREFERRED MAILING: home business

Daytime Phone: _____ Evening Phone: _____

home business home business

Fax: _____ E-mail Address: _____

DIRECTORY INFORMATION. One of the many benefits of Academy membership is a listing in and access to the online membership directory, located in the members-only section of the Web site. Only members will be able to access the information. (Your contact information will be shown as above.) If this section is left blank, you will not appear in the directory.

- Yes.** Include my business contact information in the Academy online membership directory.
- Yes.** Include my home contact information in the Academy online membership directory.
- No.** I do not wish to be included in the directory.

SHARED INTEREST GROUPS. Another benefit of Academy membership is the Shared Interest Groups (SIGs). You may join as many as you like. Please indicate below other SIGs you would like to join or a new group that you would like to see us develop.

- Administration Infection Control Juveniles Legal Issues Mental Health
- Public Health Quality Improvement Research
- Other: _____

ACADEMY COMMITTEES. If you would like to serve on an Academy Committee, please indicate the committees in which you are interested (i.e, 1 = most interested, 2 = somewhat interested).

_____ Education _____ Membership and Recruitment _____ Mentoring
_____ Shared Interest Groups

PAYMENT INFORMATION. Membership dues are \$75.

Make checks payable to the Academy of Correctional Health Professionals (ACHP).

Academy Scholarship Fund donation: \$10 \$25 \$50 Other \$ _____

Please bill the Visa MasterCard American Express indicated below:

Name as shown on the card (Print): _____

Card #: _____ Expiration date: _____

Signature: _____

Billing address (if different from mailing address): _____

Please return this renewal form and payment to:

Academy of Correctional Health Professionals
P.O. Box 11117
Chicago, IL 60611
Fax: (773) 880-2424