American College of Lifestyle Medicine

PO Box 6432, Chesterfield, MO 63006
P: (971) 983-5383
Email: membership@lifestylemedicine.org
www.lifestylemedicine.org

Membership Application

Name: _____ Credential(s):_____
First / MI / Last

Job Title: _____ Company:_____

Email: _____ Cell Phone:_____

Shipping Address: _____
Address / City / State / Zip

Billing Address: _____
Address / City / State / Zip

Current License (Type/Number): _____ Accepting New Clients? _____

How did you hear about ACLM? _____

Description of interest and/or experience in Lifestyle Medicine:

Payment:

◯ Check — I will send payment to address listed below.

◯ Credit Card — MC / VISA / American Express

◯ manual renewal ◯ autorenewal renewal

Cardholder name _____

Number _____ Exp. _____ Sec Code _____

$_____ Annual Membership Dues

$_____ Subscribe to AJLM Journal ($20) *included in $249 Memberships*

$_____ New Member Application Processing Fee ($25)

$_____ Optional one-time donation
(ACLM is a 501(c)3 IRS approved non-profit charitable organization)

$_____ TOTAL

Membership Levels:
Visit our website for a list of level descriptions

◯ $249 - Physician, Doctoral, or Healthcare Executive

◯ $149 - Professional

◯ $99 - Affiliate

◯ $45 - Retired

◯ $30 - Student/Trainee

NOTE: A one-time new member processing fee of $25 will be added for new membership applications.

◯ I will send by mail to:
PO Box 6432 Chesterfield, MO 63006

◯ I will email to:
membership@lifestylemedicine.org

I hereby agree to support the American College of Lifestyle Medicine, its bylaws, and to practice in accordance with the principles and guidelines established by the College.

Signature: _____ Date: _____

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Employment or Business Information

Employer or Business Name: _____

Address: _____
Address / City / State / Zip

Professional Website: _____

Email: _____ Phone: _____

Education

Graduuate degree(s)_____ School Name: _____ Date: _____

Medical degree(s)_____ School Name: _____ Date: _____

Other degree(s) _____ School Name: _____ Date: _____

Internship: _____
Program / Location / Dates

Residency: _____
Program / Location / Dates

Board Certification(s):

_____
Board / Date

_____
Board / Date

Other certification, license and/or specialty information: _____

Other Professional Association Memberships: _____