



**THE AMERICAN COLLEGE OF LIFESTYLE  
APPLICATION OF MEMBERSHIP**

\_\_\_\_\_  
(Date)

1.\* I hereby apply for: (circle One) Physician Professional Retired Associate Affiliate Training (\* = required )

2.\* Name: \_\_\_\_\_ 3. Gender: M F 4. Date of birth: \_\_\_\_\_  
(Last) (First) (MI) (mm/dd/yyyy)

5.\* Mailing address: \_\_\_\_\_

6. Business address: \_\_\_\_\_ City State Zip Country

Company name: \_\_\_\_\_ Dpt: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

7.\* Referred by/How you heard about ACLM: \_\_\_\_\_

8.\* Description of interest and experience in Lifestyle Medicine. (Feel free to use the back of this form.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Primary phone: \_\_\_\_\_ 10. Fax: \_\_\_\_\_

11. Website URL: \_\_\_\_\_ 12. Email \_\_\_\_\_

13. Graduate degree(s): \_\_\_\_\_ Conferred by: \_\_\_\_\_ Date: \_\_\_\_\_

14. Medical degree (circle): **MD DO** Conferred by: \_\_\_\_\_ Date: \_\_\_\_\_

15. Other degree(s): \_\_\_\_\_ Conferred by: \_\_\_\_\_ Date: \_\_\_\_\_

16.\* Clinical license: \_\_\_\_\_  
(License number) (State) (Date)

17. Internship: \_\_\_\_\_  
(Program) (Location) (Dates)

18. Residency: \_\_\_\_\_  
(Program) (Location) (Dates)

19. Board Certification(s): \_\_\_\_\_  
(Board) (Date) (Board) (Date)

20. If I am accepted for membership in the American College of Lifestyle Medicine I agree to support its Bylaws and to practice in accordance with the principles and guidelines established by the College.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

21. Fees: One time Processing Fee \$35.00  
Annual Dues + \_\_\_\_\_ \$200 Professional, Physician, & Associate;  
\$100 Affiliate, \$45 Retired, \$30 Training  
TOTAL \_\_\_\_\_ → → Please make check or money order payable to:

22.  Mail application, **American College of Lifestyle Medicine**  
 payment and 612 Glatt Circle, Woodburn, OR 97071  
 copy of CV to address at right admin@lifestylemedicine.org ~ [www.lifestylemedicine.org](http://www.lifestylemedicine.org)  
Or FAX it to: 971-983-5384  
 If you are accepting patients, please include a photocopy of your current license.