

ACVP SCHOOL MEMBERSHIP APPLICATION

General Information

Contact Name: _____
Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____

School Specialties

Invasive Noninvasive Echo Peripheral Vascular
 Other _____

Instructors Able to Teach Review Courses

Exam Area

Number of students enrolled: _____

Number of students expected to graduate in 2017/18: _____

Please provide us with three topics you would like to see covered in future publications designed to support your work or information for your students: _____

Payment Information – *School Membership @ \$250.00/annually*

Check Credit Card (MC/Visa/Amex) PO
CC: _____ Exp.: _____
CCV: _____ Billing Address: _____
Signature: _____

Please attach the list of your students along with their emails and contact information. All students of members programs receive benefits complimentary!!

<p>Call, fax or email... Phone: 804.632.0078 Fax: 804.639.9212 Email: peggymcelgunn@comcast.net</p>	<p>Or return to... ACVP – School Membership P.O. Box 2007 Midlothian, VA 23113</p>
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