



Carolinas Chapter – AACE
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Carolinas Chapter

Application for Membership
Complete this form or join online at www.cc-aace.org

Section I

Full Name: _____ Credentials: MD, DO, _____

Male Female Date of Birth: _____ Married? Yes Spouse's Name _____

Email: _____ Cell Phone: _____

Practice Name: _____ Fax Number: _____

Business Address (preferred mailing address? Yes): _____ City, State, Zip: _____ Business Telephone: _____

Home Address (preferred mailing address? Yes): _____ City, State, Zip: _____ Home Telephone: _____

Section II

Medical School: _____ Year of Completion: _____

Residency Program: _____ Year of Completion: _____

Fellowship Program: _____ Year of Completion: _____

Medical License Number: _____ NC SC None

Are you a member of the American Academy of Clinical Endocrinologists? Yes No

Is your practice limited to endocrinology? Yes No If no, additional practice area(s): _____

Section III

Membership Type: MD or DO (Dues=\$125) Resident or Fellow-in-Training (Dues=\$0)
 Senior (retired from active clinical practice) (Dues=\$0)

Payment Options: Check payable to CC-AACE MasterCard Visa

Card number: _____ Exp. Date: _____ CVV: _____

Applicant's Signature _____ Date: _____

Complete and return this form by mail or fax to:
CC-AACE, PO Box 27167, Raleigh, NC 27611 | Fax: 919-833-2023

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