2010 NCCRA Membership Application

PLEASE ANSWER ALL! (If you do not have an email address please put "none".)

➔➔➔**Incomplete forms** will not be processed🡐🡐🡐

Last Name: ________________________________ **First:** ____________________________ **MI:** _____

Street Address:

____

City: ____________________________________ **State:** ________________ **Zip:** _________________

Home Phone: (   )   -   **E-mail Address (home):** _______________________________

Work Phone: (   )   -   **E-mail Address (work):** ______________________________

Are you affiliated with a Cardiopulmonary Rehab Program? YES NO

Which region? Coastal Mountain Piedmont

Program / Institution Name: ____

Membership Classification	**Discipline**	**Role(s) -** *May serve in as many as you are qualified; please indicate all roles.*
Professional	Physician	Medical Director
Student	RN	Program Director
	Associate	Nurse
	Diploma	Nutritionist
	BSN	Mental Health Specialist
	Exercise Physiology	Vocational Rehab Counselor
	Bachelor	Exercise Physiologist
	Masters	Exercise Leader
	Doctorate	Physical Therapist
	Nutrition	Occupational Therapist
	Mental Health	Respiratory Therapist
	Masters	Office Manager / Secretary
	Doctorate	Other (Please describe)
	Vocational Rehab	______________________
	Physical Therapy	______________________
	Respiratory Therapy	
	Occupational Therapy	
	Secretarial Science	
	Other (Please describe)	

Licensure / Certification (List all):

____

AACVPR	ACSM	AARC	APA
Member Fellow	Member Fellow	Member Fellow	Member Fellow

Other Professional Memberships:____