



Abortion Care Network

RESPECT • CONNECTION • ZEST

1425 K Street NW #350
Washington, DC 20005
202-419-1444

Individual Clinician Membership Application

Thank you for your interest in ACN. Now more than ever abortion providers need support. Now more than ever our voices and the voices of the women we serve need to be heard in the national conversation.

The membership process begins with you filling out this application. Because of security concerns we ask that you offer two abortion provider references. Once we have received your membership application and check, the Membership Committee of the ACN Board of Directors will meet to consider your membership request. The process takes a few weeks since our full Board meets monthly and will determine final approval.

Approved members receive a complete ACN Membership Packet which includes a description of current membership benefits and access information to 'members only' features.

This membership application is for an individual clinician providing abortion services who does not own a clinic or practice. Yearly dues of \$500 begin in January, so they are prorated through the year based on the quarter in which your application is received.

Prorating by Quarter, based on the date application is received:

1. January, February, March application: \$500
2. April, May, June: \$375
3. July, August, September: \$250
4. October, November, December: \$125

Please complete the following:

(Print!)

Your name and title: _____

Names of Clinic(s) in which you provide abortions: _____ city/state

Your Mailing address: _____

Phone # _____

Fax: _____

E-mail _____

If membership is approved, what e-mail would you like added to ACNtalk:

What kinds of abortions do you perform?

_____ first trimester surgical

_____ medication abortions

_____ second trimester surgical

The Abortion Care Network is committed to furthering respect for women and eliminating the stigma attached to abortion. How do you demonstrate these principles in your practice?

How could the Abortion Care Network most assist you in your practice?

What would you like to contribute to the Abortion Care Network?

Please list two (2) professional references (plus contact information) for abortion colleagues familiar with your work.

1. _____

2. _____

I support the work of the Abortion Care Network in its commitment to connect the abortion care community by creating educational and networking opportunities to increase respect for women and challenge stigma surrounding abortion.

Signature: _____

Print Name and title _____

Date _____

Please mail this application with a check for dues based on the quarter in which your application is submitted to:

Abortion Care Network, P.O. Box 404, Rowe, NM 87562

Our membership Committee will consider your application as soon as possible and you should hear from us within one month.

Questions? Contact Charlotte Taft, ACN Director ACN, ctaft@abortioncarenetwork.org, or 505-490-2084