American College of Physicians Assistants

November 24, 1972

Dear Colleagues,

As a result of our most recent trip to Chicago in which we met with the Directors of Health Manpower, of Medical Education and other American Medical Association Council Executives, specific direction was given which caused us to return with the confidence that the American College of Physicians Assistants will undoubtedly be the national physician's assistant organization called upon by the existing medical authorities in those matters of business concerning the physician's assistants.

Subsequently, we have met with the American Academy of Physician's Associates and find our philosophy, concept and direction similar. At this point in time it appears that the near future will see a uniting of these two national organizations providing political, economic, and philosophical direction that will allow all members to have a voice in the destiny of the profession of the physician's assistant.

It appears that only through immediate and active participation of the total community of physician's assistants will we be able to accomplish those things necessary to insure the physician's assistant his place with the medical team in the medical community.

If you would like to be a functioning part of this mobility whose goal is representation of the members of our profession before the existing medical and legislative authorities, act now by contacting The College for more information and for an application for membership. As you know from your own personal research into the medical and governmental literature, we must group together now into a concrete professional, moral person as we conceive ourselves to be or be grouped by other authorities who may only patch-work us together out of their compromised concepts of what we are. Let us hear from you soon as you are definitely needed to mold the public image of the physician's assistant.

Sincerely yours,

The National Executive Committee
American College of Physicians Assistants

Roy W. Snell

Roy W. Snell, P.A.
Secretary-Treasurer

2314 UPLAND PLACE • CINCINNATI, OHIO 45206

AMERICAN COLLEGE OF PHYSICIAN'S ASSISTANTS
ASSOCIATION GROUP INSURANCE BENEFIT PROGRAM
(Available only to members in good standing)

OPTIONAL LIFE AND DISABILITY INSURANCE
(Underwritten by the Prudential Life Insurance Company).

$12,000---Life and AD&D-$3.72 Monthly (Under Age 30).
$120.00---Twenty-six (26) weeks-1st Day Accident, 8th Day Sickness, Disability Income-$5.76 Monthly (Under Age 30)**
$2,000----Life Insurance on Spouse $.46 Monthly (Under Age 30).
$1,000----On all children (6mos.-19yrs)

TOTAL MONTHLY COST-$9.94 (Paid at same time as Monthly Membership Dues).

Various other benefits are available in certain areas:

1. Health Care
2. Personal Accident Insurance
3. Survivor Income Insurance

*Assumes $10,000 Annual Income-Lower or Higher amounts available based on income.

**Not available in New York, New Jersey, Rhode Island, California, or Hawaii because of existing State Disability Laws.

***Rates increase slightly over age 30 in 5 year brackets

MALPRACTICE LIABILITY
LIMITS OF LIABILITY

*$25,000---any one patient
*$75,000---all claims against assured
$ 1,000---Deductable per Claim
$ 2,500---Annual Aggregate Deductible

Pd By ACPA.

Custom made coverage for Physician's Assistants who are members in good standing of The American College of Physician's Assistants. Provides coverage previously not available for the Modern Physician's Assistant (According to membership criteria for the American College of Physician's Assistants).

**Monthly Premium-$10..00 (Paid at same time as membership dues).

*Higher Limits will be available in the future.

**Except California and New York which are higher.

NOTE: THIS IS A BRIEF EXPLANATION OF BENEFITS ONLY AND IS NOT A CONTRACTUAL FORM

American College of Physicians Assistants

APPLICATION FOR ADMISSION

(Check One)

Mr. _____
Mrs. _____
Miss _____

Last First Middle Social Security

Permanent Home Address: _____
Street & No. City State Zip

Mailing Address: _____

Place of Residence: _____

Birth Place: _____
City State or County Birth Date: Mo./Day/Yr.

Marital Status: Single _____ Married _____ (Check One)

Spouse's Name: _____
First Middle Maiden

Name of High School: _____ Date of Graduation: _____

Address of High School: _____
Street & No. City State Zip

List all Schools, Colleges, Professional Schools attended since leaving High School:

Name & Address	City & State	Date of Attendance	Grad Date	Degree

Parents: _____ Guardian: _____ (Check One)

Father: Living: _____ Deceased: _____ (Check One)

Mother: Living: _____ Deceased: _____ (Check One)

Father's Name: _____

Father's Address: _____
Street & No. City State Zip

Mother's Name: _____

Mother's Address: _____
Street & No. City State Zip

Have you ever been convicted for an act committed in violation of any law, other than minor traffic violation? Yes _____ No _____ (Check One)

Have you ever been the subject of disciplinary proceedings or reprimanded by an administrative agency or professional association?
Yes _____ No _____ (Check One)

Of what Professional Associations or Societies are you a member in good standing? _____

Have you or any of your Partners, Nurses, Technicians or Assistants any Physical Imfirmity? Yes _____ No _____ (Check One)

Do you own, wholly or in part, or operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes _____ No _____ (Check One)

Have you any other Malpractice Insurance?
Yes _____ No _____ (Check One)

Have Lloyd's Underwriters or any company ever:
a. cancelled,
b. declined,
c. refuse to renew or,
d. only accepted on special terms your Malpractice Insurance,
Yes _____ No _____ (Check One)

Have any claims or suits for Malpractice been made against you?
Yes _____ No _____ (Check One)

Are you aware of any claims or suits for Malpractice that may have been made against any of your partners, assistants, nurses or technicians?
Yes _____ No _____ (Check One)

Are you aware of any circumstances which may result in any such claimor suit being made? Yes _____ No _____ (Check One)

If your answer to any question is "YES" please explain below.

MEDICAL EXPERIENCES

(A) Total months of direct patient contact. _____

(B) Months in:

1. Medicine ____
2. Surgery ____
3. Pediatrics ____
4. Psychiatry _____
5. Ob. & Gyn. _____
6. Other _____ (Specify)

(C) Give the following information of all medically positions held:

From Mo. & Yr.	To Mo. & Yr.	Position	Des. of Duties

(D) Check whether you practice with:

1. _____ A General Practitioner
2. _____ A Surgeon (State specialty of Surgeon).
3. _____ A General Practitioner and Surgeon.
4. _____ Other Medical Personnel (Please Specify). _____

MISCELLANEOUS INFORMATION:

(A) Present Occupation: _____

(B) Name of Supervisor: _____

(C) Name of Employer: _____

(D) Address of Employer: _____
Street & No. City State Zip

(E) List at least one (1) M.D., and two (2) professional (outside your family), who may be used as references. Give their names, position held, plus addresses.

1. _____

2. _____

3. _____

I hereby affirm that to the best of my knowledge all information furnished on this form is complete and accurate. I understand that withholding information requested - (except where it is voluntary for me to furnish that information) or giving false information may make me ineligible for admission, and if information found false after enrollment I may be dismissed from the Association. I also agree that this application shall be the basis of the insurance benefits I receive from this membership.

DATE: _____ _____
Signature of Applicant