



Members' Attorney Program

Participation form

MAP participation is available at no additional cost to any licensed attorney working at an office holding a current ACA company (firm) membership or who has a creditor membership. Completion of this form assists ACA in verifying eligibility for MAP participation.

Name: _____ Title: _____

Company: _____ Co. Member ID # (if known): _____

Address: _____

City: _____ State: _____ Zip: _____

Direct phone: _____ Fax: _____

Email address (required for access to the MAP community on the Hub): _____

I am licensed in good standing to practice law in the state(s) of: _____

How did you learn about MAP? Mailing ACA website Co-worker Other: _____

Referred by _____

By signing below I certify:

1. My company/firm is a current member of ACA International or I hold an ACA creditor membership.
2. I am an active, licensed attorney in the state(s) indicated above.
3. I agree to be bound by and support the purposes of ACA's governing documents, including the association bylaws, standard operating procedures, and the codes, procedures and rules governing member conduct which may be found at www.acainternational.org/governance, and which may be amended from time to time.
4. I do not threaten, initiate, or maintain consumer-protection related actions against members of ACA International.
5. I do not supervise, manage, oversee the work of, or otherwise provide assistance to any legal professionals who threaten, initiate or maintain consumer-protection related actions against members of ACA International. I will not directly or indirectly assist such attorneys or professionals, nor any other individuals providing assistance to them, in gaining access to ACA exclusive member benefits and privileges, or share with them any information originating from ACA.
6. I have read and agree to abide by the terms of the Hub Community Code of Conduct (<http://community.acainternational.org/acal/CodeofConduct>) when accessing the Hub.

To the extent my circumstances change with respect to the above certifications, I acknowledge my continuing obligation to so inform ACA's membership department.

Signature _____ Date _____

Return completed form to membership@acainternational.org or fax to (952) 915-3955.

Questions? Contact the ACA Membership Department at email above or call 952-926-6547 (menu option 1).