Members' Attorney Program

Participation Form

MAP participation is available to licensed attorneys who represent or provide services to one or more members of the Association in the area of credit or collection law. Completion of this form will assist ACA in verifying eligibility for MAP participation.

ACA™ INTERNATIONAL
The Association of Credit and Collection Professionals

Name: _____ **Title:** _____

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

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Direct phone: _____ **Fax:** _____

E-mail address: _____
(required for access to 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.
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/about/leadgov/* 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* (*https://hub.acainternational.org/terms-of-access/*) 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 *memberservices@acainternational.org* or fax to (952) 926-1624.