



# ASPPS

## American Society of Professionals in Patient Safety

### Affiliate Membership Application

#### Affiliate Member

Any individual who has a strong interest in learning about and supporting patient safety work, but is ineligible for Professional, Patient Advocate, or Student membership.

- One-year membership: \$75
- Two-year membership: \$135
- Three-year membership: \$198
- Four-year membership: \$258
- Five-year membership: \$315
- Lifetime membership: \$1,500

#### Member Profile

<sup>\*</sup>Denotes Required Field

**\*Name:** \_\_\_\_\_  
First Middle Last

Please list all Credentials, Professional Designations, and Certificates:

\_\_\_\_\_

**\*Title:** \_\_\_\_\_

Please list any additional titles you hold related to patient safety: \_\_\_\_\_

**\*Organization:** \_\_\_\_\_

**\*Address Type** (Please circle): **Work** **Home** **Other** \_\_\_\_\_ **Gender** (Please circle): **Male** **Female**

**\*Address:** \_\_\_\_\_ **\*City:** \_\_\_\_\_

**\*State/Province:** \_\_\_\_\_ **\*Zip:** \_\_\_\_\_ **\*Country:** \_\_\_\_\_

**\*Preferred Email** (Please circle): **Work** **Personal** **Alternate** **\*Email:** \_\_\_\_\_

**\*Preferred Phone Number** (Please circle): **Work** **Home** **Mobile** **\*Phone Number:** \_\_\_\_\_

Which of the following best describes your ethnicity?

- African American
- American Indian
- Asian or Pacific Islander
- Caucasian
- Hispanic
- Other \_\_\_\_\_
- I choose not to answer

\*Which of the following best describes your organization?

- Ambulatory Care Facility/Outpatient Clinic
- Physician's Office
- Hospital
- Academic Medical Center
- Military Healthcare Facility
- Long-term Care Facility
- Home Care Organization
- Academic Setting – Student
- Academic Setting – Faculty
- Hospital Engagement Network (HEN)
- Dental Clinic
- Not-for-Profit Organization/Foundation
- Medical Device/Pharmaceutical Industry/Solutions Provider
- Other \_\_\_\_\_

Your privacy is important to us. We will not share, sell, or distribute personal information to outside parties.

IHI • 53 State Street, 19<sup>th</sup> Floor • Boston, MA 02109

ASPPS Member Services: 617.391.9931 • [ASPPSinfo@ihi.org](mailto:ASPPSinfo@ihi.org)

**\*Which of the following best describes the approximate size of your organization?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 1-100 (full time employees) | <input type="checkbox"/> 501-1,000       | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> 101-250                     | <input type="checkbox"/> 1,001-5,000     |   |
| <input type="checkbox"/> 251-500                     | <input type="checkbox"/> More than 5,000 |   |

**\*Which of the following best describes your primary role within your organization?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Patient Safety Officer | <input type="checkbox"/> Performance Improvement Director              | <input type="checkbox"/> Chief Nursing Officer/ Nurse Manager |
| <input type="checkbox"/> Patient Safety Staff   | <input type="checkbox"/> Performance Improvement Staff                 | <input type="checkbox"/> Other Executive                      |
| <input type="checkbox"/> Quality Director       | <input type="checkbox"/> Chief Medical Officer and/or Medical Director | <input type="checkbox"/> Pharmacy Staff                       |
| <input type="checkbox"/> Quality Staff          |  | <input type="checkbox"/> Nursing Staff                        |
| <input type="checkbox"/> Risk Officer/Director  |  | <input type="checkbox"/> Physician Staff                      |
| <input type="checkbox"/> Risk Staff             |  | <input type="checkbox"/> Other _____                          |

**\*Do we have your permission to include your name, credentials, and organization (name, city, state, country) in the ASPPS membership directory and in a new member announcement?  Yes  No**

**How did you hear about the American Society of Professionals in Patient Safety?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Article/News         | <input type="checkbox"/> LinkedIn                 | <input type="checkbox"/> Trade Journal Advertisement |
| <input type="checkbox"/> Conference/Tradeshaw | <input type="checkbox"/> NPSF/ASPPS Email         | <input type="checkbox"/> Twitter                     |
| <input type="checkbox"/> Direct Mail          | <input type="checkbox"/> NPSF/ASPPS Website       | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Facebook             | <input type="checkbox"/> Other Website            |  |
| <input type="checkbox"/> Friend/Colleague     | <input type="checkbox"/> Professional Association |  |

**Please list other professional membership associations to which you belong (e.g. American Association of Colleges of Nursing, American College of Physicians, American Medical Association)**

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# ASPPS

American Society of Professionals in Patient Safety

## Affiliate Membership Application ... continued

### You must complete payment information for your application to be processed.

**Please check one:**

- |   |   |
|---|---|
| <input type="checkbox"/> One-year membership: \$75    | <input type="checkbox"/> Four-year membership: \$258  |
| <input type="checkbox"/> Two-year membership: \$135   | <input type="checkbox"/> Five-year membership: \$315  |
| <input type="checkbox"/> Three-year membership: \$198 | <input type="checkbox"/> Lifetime membership: \$1,500 |

**Payment Method:**

- Check enclosed**      please make check payable to:

**Institute for Healthcare Improvement**  
53 State Street, 19<sup>th</sup> Floor  
Boston, MA 02109

- Credit card**      please complete all fields below and submit via email to:  
[ASPPSinfo@ihi.org](mailto:ASPPSinfo@ihi.org)

**DO NOT MAIL IN CREDIT CARD INFORMATION**

**Credit card information:**

*Please print clearly*

Please charge to (circle one):    VISA                      MASTERCARD                      AMEX

CARD NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_      CARD VERIFICATION CODE: \_\_\_\_\_

NAME ON CARD: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_      STATE: \_\_\_\_\_      ZIP CODE: \_\_\_\_\_

AUTHORIZED SIGNATURE: \_\_\_\_\_      DATE: \_\_\_\_\_

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