ASPPS

American Society of Professionals in Patient Safety

Student Membership Application

Student Member

You must be a student and have a student email address when applying for student membership. If you select a 2-year, 3-year, or 4-year student membership, you must continue to be a student and have a student email address through all years of membership.

- ☐ **One-year membership: $75**
- ☐ **Two-year membership: $135**
- ☐ **Three-year membership: $198**
- ☐ **Four-year membership: $258**

Member Profile

*Denotes Required Field

***Name:** _____
First Middle Last

***School Name**: _____

***Major**: _____ ***Degree Pursing:** _____

***Graduation (Month/Year):** _____

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

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

IHI • 53 State Street, 19th Floor • Boston, MA 02109
ASPPS Member Services: 617.391.9931 • ASPPSinfo@ihi.org

***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 _____

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

- ☐ 1-100 (full time employees)
- ☐ 101-250
- ☐ 251-500
- ☐ 501-1,000
- ☐ 1,001-5,000
- ☐ More than 5,000
- ☐ Not Applicable

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

- ☐ Patient Safety Officer
- ☐ Patient Safety Staff
- ☐ Quality Director
- ☐ Quality Staff
- ☐ Risk Officer/Director
- ☐ Risk Staff
- ☐ Performance Improvement Director
- ☐ Performance Improvement Staff
- ☐ Chief Medical Officer and/or Medical Director
- ☐ Chief Nursing Officer/ Nurse Manager
- ☐ Other Executive
- ☐ Pharmacy Staff
- ☐ Nursing Staff
- ☐ Physician Staff
- ☐ 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?

- ☐ Article/News
- ☐ Conference/Tradeshow
- ☐ Direct Mail
- ☐ Facebook
- ☐ Friend/Colleague
- ☐ LinkedIn
- ☐ NPSF/ASPPS Email
- ☐ NPSF/ASPPS Website
- ☐ Other Website
- ☐ Professional Association
- ☐ Trade Journal Advertisement
- ☐ Twitter
- ☐ Other _____

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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Student Membership Application ... continued

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

Please check one:

- ☐ **One-year membership: $75**
- ☐ **Two-year membership: $135**
- ☐ **Three-year membership: $198**
- ☐ **Four-year membership: $258**

Payment Method:

☐ **Check enclosed** please make check payable to:

Institute for Healthcare Improvement
53 State Street, 19th Floor
Boston, MA 02109

☐ **Credit card** please complete all fields below and submit via email to: 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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