



ASPPS

American Society of Professionals in Patient Safety

Patient Advocate Membership Application

Patient Advocate Member

Any individual who is actively working in the patient safety field representing the patient and family perspective.

- | | |
|---|--|
| <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 | |

Member Profile

^{*}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?

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Hispanic | |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Other _____ | |

*Which of the following best describes your organization?

- | | | |
|---|--|--|
| <input type="checkbox"/> Ambulatory Care Facility/Outpatient Clinic | <input type="checkbox"/> Home Care Organization | <input type="checkbox"/> Not-for-Profit Organization/Foundation |
| <input type="checkbox"/> Physician's Office | <input type="checkbox"/> Academic Setting – Student | <input type="checkbox"/> Medical Device/Pharmaceutical Industry/Solutions Provider |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Academic Setting – Faculty | |
| <input type="checkbox"/> Academic Medical Center | <input type="checkbox"/> Hospital Engagement Network (HEN) | |
| <input type="checkbox"/> Military Healthcare Facility | <input type="checkbox"/> Dental Clinic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Long-term Care Facility | | |

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 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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Patient Advocate 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
- Five-year membership: \$315

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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