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.

- ☐ **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

*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, 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?**

- ☐ 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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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**
- ☐ **Lifetime membership: $1,500**

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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