

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 Caucasian I choose not to answer
 American Indian Hispanic
 Asian or Pacific Islander 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 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"/> Other _____ |
| <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"/> Long-term Care Facility | | |

***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

Student 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"/> Three-year membership: \$198 |
| <input type="checkbox"/> Two-year membership: \$135 | <input type="checkbox"/> 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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