

SPINE INTERVENTION SOCIETY  
NORTH AMERICAN/PROVISIONAL/AFFILIATE MEMBERSHIP APPLICATION  
PERSONAL & CONTACT INFORMATION



Name: First/Middle/Last \_\_\_\_\_

Nickname \_\_\_\_\_

Degree(s) \_\_\_\_\_

Specialty \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Street Address \_\_\_\_\_

Home City/State/Province/Postal Code/Country \_\_\_\_\_

Gender Female Male  
Preferred Primary Email Practice Personal  
Preferred Mailing Address Practice Personal

Practice Email \_\_\_\_\_

Personal/Permanent Email \_\_\_\_\_

Practice Phone \_\_\_\_\_

Personal Phone \_\_\_\_\_

Facebook Profile URL \_\_\_\_\_

LinkedIn Profile URL \_\_\_\_\_

Twitter Handle \_\_\_\_\_

MEMBERSHIP TYPE QUALIFICATIONS

**I am currently certified in one, or more, of the following specialties**, have attached verifying documentation, and wish to be considered for **North American Membership**  
**I will complete certification in one of the following specialties** on \_\_\_\_\_, have attached verifying documentation, and wish to be considered for **Provisional Membership**  
**I am not pursuing certification in one of the following specialties**, have no intention to attend SIS Bio-Skills Labs, and wish to be considered for **Affiliate Membership**

ANESTHESIOLOGY

NEUROLOGY

NEUROSURGERY

ORTHOPEDIC SURGERY

PHYSICAL MEDICINE  
AND REHABILITATION

RADIOLOGY

PROFESSIONAL INFORMATION

Indicate if You Currently Direct a Training Program \_\_\_\_\_

Practice Name \_\_\_\_\_

Practice Street Address \_\_\_\_\_

Practice City/State/Province/Postal Code/Country \_\_\_\_\_

Residency and Completion Date \_\_\_\_\_

Fellowship and Completion Date \_\_\_\_\_

Office Administrator \_\_\_\_\_

Office Administrator Email \_\_\_\_\_

Office Administrator Phone \_\_\_\_\_

Billing and Coding Staff Member \_\_\_\_\_

Billing and Coding Staff Member Email \_\_\_\_\_

Billing and Coding Staff Member Phone \_\_\_\_\_

DUES PAYMENT INFORMATION

Cardholder Name \_\_\_\_\_

Card Number (Amex, MC, Visa) \_\_\_\_\_

Cardholder Signature \_\_\_\_\_

Card Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_

I wish to be enrolled in Automatic Membership Renewal. (You will receive receipts and can change payment options online at any time.)  
Instead of paying with a credit card, I have included check # \_\_\_\_\_, payable in US dollars.

APPLICATION REQUIREMENTS Please indicate that you have attached all required verifying documents.

Curriculum Vitae \_\_\_\_\_ Documentation of Board Certification or Expected Date of Completion \_\_\_\_\_ Annual Membership Fee: \$395 USD

AUTHORIZATION

I hereby release from liability all representatives of the Spine Intervention Society in connection with evaluating my application, credentials, and qualifications. By signing this application I affirm that the provided information is true.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE MAIL, EMAIL, OR FAX COMPLETED APPLICATION TO:** Spine Intervention Society - Membership Department  
120 E. Ogden Ave. Ste. 202 | Hinsdale, Illinois 60521 | membership@SpineIntervention.org | fax 415.457.3495

**Spine Intervention Society**  
phone 630-203-2252 | U.S. toll free 888.255.0005 | SpineIntervention.org