

SPINE INTERVENTION SOCIETY INTERNATIONAL MEMBERSHIP APPLICATION - TIER 2



PERSONAL & CONTACT INFORMATION

Name: First/Middle/Last

Nickname

Degree(s)

Specialty

Date of Birth

Home Property Number and Street Name

Home Local Area or Village Name/City/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

QUALIFICATIONS

Membership is limited to physicians Board-certified or pursuing certification in the following specialties:

I am currently certified in one or more of the following specialties, and have attached verifying documentation.

I am not currently certified in one of the following specialties, but I expect to complete certification on _____, and have attached verifying documentation.

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

DUES PAYMENT INFORMATION

Cardholder Name

Billing Address

Billing City/State/Province/Postal Code/Country

Card Number (Amex, MC, Visa)

Card Expiration Date

Security Code

Cardholder Signature

Instead of paying with a credit card, I have included check # _____, payable in US dollars.

I wish to be enrolled in Automatic Membership Renewal. (You will receive receipts and can change payment options online at any time.)

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: \$145 USD (or \$125 with auto renew)

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