SPINE INTERVENTION SOCIETY
ACTIVE U.S. MILITARY 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 ☐ Service ☐ Personal

Preferred Mailing Address ☐ Service ☐ Personal

Service Email

Personal/Permanent Email

Service 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

Military Branch

Station Street Address

Station City/State/Postal Code/Country

Residency and Completion Date

Fellowship and Completion Date

Medical Station Office Administrator

Medical Station Office Administrator Email

Medical Station Office Administrator Phone

Medical Station Billing and Coding Staff Member

Medical Station Billing and Coding Staff Member Email

Medical Station Billing and Coding Staff Member Phone

DUES PAYMENT INFORMATION

Cardholder Name

Cardholder Signature

Card Number (Amex, MC, Visa)

Card Expiration Date Security Code

☐ 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: S145 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, and I am actively serving in the United States Military, and will notify SIS of any change to my status which would require my membership type to change.

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@sSpineIntervention.org | fax 415.457.3495

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