

Professional Membership Application

Professional Member

Any individual who is actively involved in the patient safety field in a professional capacity or whose role has an impact on patient safety.

- | | |
|---|---|
| <input type="checkbox"/> One-year membership: \$150 | <input type="checkbox"/> Four-year membership: \$516 |
| <input type="checkbox"/> Two-year membership: \$270 | <input type="checkbox"/> Five-year membership: \$630 |
| <input type="checkbox"/> Three-year membership: \$396 | <input type="checkbox"/> 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?

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Hispanic | |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Other _____ | |

*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"/> Academic Medical Center | <input type="checkbox"/> Hospital Engagement Network (HEN) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Military Healthcare Facility | <input type="checkbox"/> Dental Clinic | |
| <input type="checkbox"/> Long-term Care Facility | | |

Your privacy is important to us. We will not share, sell, or distribute personal information to outside parties.

IHI/NPSF • 280 Summer Street, 9th Floor • Boston, MA 02210

ASPSS Member Services: 617.391.9931 • Fax: 617.391.9999 • ASPSSinfo@npsf.org

***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

Professional Membership Application ... continued

**You must complete payment information
for your application to be processed.**

Please check one:

- | | |
|---|---|
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Payment Method:

- Check enclosed** please make check payable to:

*Institute for Healthcare Improvement/
National Patient Safety Foundation
280 Summer Street, 9th Floor
Boston, MA 02210*

- Credit card** please complete all fields below and submit via:
Fax – 617-391-9999
Email – ASPPSinfo@npsf.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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