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.

- One-year membership: $150
- Two-year membership: $270
- Three-year membership: $396
- Four-year membership: $516
- Five-year membership: $630
- Lifetime membership: $1,500

Member Profile

*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?

- African American
- American Indian
- Asian or Pacific Islander
- Caucasian
- Hispanic
- Other

- I choose not to answer

*Which of the following best describes your organization?

- Ambulatory Care Facility/Outpatient Clinic
- Physician’s Office
- Hospital
- Academic Medical Center
- Military Healthcare Facility
- Long-term Care Facility
- Home Care Organization
- Academic Setting – Student
- Academic Setting – Faculty
- Hospital Engagement Network (HEN)
- Dental Clinic
- Not-for-Profit Organization/Foundation
- Medical Device/Pharmaceutical Industry/Solutions Provider
- 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 the approximate size of your organization?
- 1-100 (full time employees)
- 101-250
- 251-500
- 501-1,000
- 1,001-5,000
- More than 5,000
- Not Applicable

*Which of the following best describes your primary role within your organization?
- Patient Safety Officer
- Patient Safety Staff
- Quality Director
- Quality Staff
- Risk Officer/Director
- Risk Staff
- Performance Improvement Director
- Performance Improvement Staff
- Chief Medical Officer and/or Medical Director
- Chief Nursing Officer/ Nurse Manager
- Other Executive
- Pharmacy Staff
- Nursing Staff
- Physician Staff
- 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?
- Article/News
- Conference/Tradeshow
- Direct Mail
- Facebook
- Friend/Colleague
- LinkedIn
- NPSF/ASPPS Email
- NPSF/ASPPS Website
- Other Website
- Professional Association
- Trade Journal Advertisement
- Twitter
- Other

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)

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

Please check one:

- □ One-year membership: $150
- □ Two-year membership: $270
- □ Three-year membership: $396
- □ Four-year membership: $516
- □ Five-year membership: $630
- □ Lifetime membership: $1,500

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: ________________

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