

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 _____

Card Number (Amex, MC, Visa) _____

Cardholder Signature _____

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: \$95 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, 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@spinalinjection.org | fax 415.457.3495

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