# SPINE INTERVENTION SOCIETY
# NORTH AMERICAN/PROVISIONAL 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 ☐ 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

Office Administrator

Office Administrator Email

Office Administrator Phone

Billing and Coding Staff Member

Billing and Coding Staff Member Email

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: $395 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.

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