# ASPPS

American Society of Professionals in Patient Safety

## 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

*Denotes Reauired 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?**

- ☐ 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/NPSF • 20 University Road, 7th Floor • Cambridge, MA 02138
ASPPS Member Services: 617.391.9931 • Fax: 617.391.9999 • 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)**

_____

_____

_____

_____

# 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:**

- ☐ **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/*
*National Patient Safety Foundation*
20 University Road, 7th Floor
Cambridge, MA 02138

☐ **Credit card** please complete all fields below and submit via:
Fax – 617-391-9999
Email – 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:** _____

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