

# Membership Application

## Personal Information:

Male  
 Female

|  |  |                 |  |
|--|--|-----------------|--|
| Last Name  | First  | Middle Initial  | Date of Birth (mm/dd/yyyy)                                 |
| Institution  |  | Department      | Position   |
| <input type="radio"/> Home <input type="radio"/> Office<br>Preferred Mailing Address |  | Street Address  |  |
| City<br>(   )  | <input type="radio"/> Home<br><input type="radio"/> Office | State<br>(   )  | <input type="radio"/> Home<br><input type="radio"/> Office |
| Phone Number   | Fax*   | Zip/Postal Code | Country  |
|  |  | Email           |  |

**Privacy Statement:** The Society of Critical Care Medicine periodically rents its membership list to organizations that wish to market educational courses, publications and other products or services that are of interest to critical care practitioners. All such requests are screened to ensure that these offerings are appropriate and in good taste. If you do not want SCCM to provide your name to other companies for the purpose of receiving these marketing offers, please check here .

\*By including your fax number above and signing here, you give consent to receive faxes sent by SCCM. \_\_\_\_\_  
Signature Date

### Profession: (check the appropriate classifications)

- |   |                                    |   |  |
|---|------------------------------------|---|--|
| <input type="radio"/> Industry Representative | <input type="radio"/> In-training  | <input type="radio"/> Nurse               | <input type="radio"/> Nutrition Support Specialist |
| <input type="radio"/> Pharmacist              | <input type="radio"/> Physician    | <input type="radio"/> Physician Assistant | <input type="radio"/> Respiratory Therapist        |
| <input type="radio"/> Scientist               | <input type="radio"/> Veterinarian | <input type="radio"/> Other _____         |  |

Years of Practice: \_\_\_\_\_

### Highest Education Achieved:

|             |  |
|-------------|--|
| Institution | Type of Residency (if applicable)        |
| Location    | From: (mm/dd/yyyy)      To: (mm/dd/yyyy) |

### Degree/Credentials: (check all that apply)

- ACNP    BA    BS    BSN    CCRN    CNS    CRNA    CRNP    DNSc    DO    DVM    EdD    MB    MBA    MD    MPH  
 MS    MSN    MSW    PharmD    PhD    RN    RPh    RRT    ScD    Other \_\_\_\_\_

### Board Certifications/Year of Certification: (Example: 2003)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> _____ Advanced Practice Nursing | <input type="checkbox"/> _____ Anesthesiology    | <input type="checkbox"/> _____ Critical Care Medicine | <input type="checkbox"/> _____ Critical Care Nursing |
| <input type="checkbox"/> _____ Emergency Medicine        | <input type="checkbox"/> _____ Internal Medicine | <input type="checkbox"/> _____ Pediatrics             | <input type="checkbox"/> _____ Pharmacotherapy       |
| <input type="checkbox"/> _____ Respiratory Care          | <input type="checkbox"/> _____ Surgery           | <input type="checkbox"/> _____ Other: _____           |  |

## Specialty Sections:

Membership in SCCM includes the option to join up to three specialty sections. Please note that Pediatric Section membership has an associated fee of \$55, which includes a subscription to *Pediatric Critical Care Medicine*. There is no additional charge for joining other sections.

(Please check a maximum of three):

- Anesthesiology    Clinical Pharmacy & Pharmacology  
 Emergency Medicine    Industry & Technology  
 Internal Medicine    In-training    Neuroscience  
 Nursing    Osteopathic Medicine    Pediatric  
 Physician Assistants    Respiratory Care    Surgery  
 Uniformed Services

## Chapters:

Membership in SCCM includes the option to join one of eleven state and regional chapters for an additional fee of \$45. (In-training members may join at no cost.) If you would like to join an SCCM chapter, please check the chapter in your geographical area.

- California    Carolina/Virginia (includes VA, NC, and SC)    Michigan  
 New England (includes ME, VT, NH, MA, CT, and RI)    New Jersey  
 North Central (includes IA, MN, ND, SD, and WI)    Ohio    Oregon  
 Pennsylvania    Southeast (includes AR, LA, KY, TN, MS, AL, and GA)  
 Washington, DC

**Please complete the other side of this application.**



## Membership Options:

### Physician

**Dues \$325** – Available to physicians and provides full privileges of membership. Physicians residing outside the United States may choose International Physician membership, if they do not wish to have full voting privileges.

### Allied Healthcare Professional

**Dues \$120** – Available to advanced practice nurses, registered nurses, pharmacists, physician assistants, respiratory therapists, scientists and other allied healthcare professionals and industry personnel. Provides full privileges of membership.

### International Physician

**Dues \$240** – Available to physicians residing outside of the United States. Provides privileges of membership, except the right to make motions, vote, or hold office.

### NEW! Young Physician

**Dues \$175** – Available to individuals who have completed their fellowship training programs within the last three years and are not currently Physician members. Membership may be renewed annually at this rate until three years after the physician completes the fellowship program. Documentation verifying the fellowship program completion date is required. Provides full privileges of membership.

### In-training

(check one):  Fellow  Resident  Student

**Dues \$70** – Available to individuals in specialty training programs or pursuing education in healthcare and related fields. Provides full privileges of membership, except the right to make motions, vote, or hold office. Membership may be renewed annually at the in-training rate until the year the member completes his/her training program. In-training applicants must submit documentation verifying training status, including program director's name, date(s) of training, and the name of the institution.

**Additional Information (optional):** This information will remain confidential and will be used for internal purposes only.

#### Primary Employment Setting:

- Solo/Two-physician practice  Pediatric/Multispecialty group practice  Staff Model HMO  Medical school or patient university  Government hospital/clinic  
 Non-government hospital/clinic  
 Other \_\_\_\_\_

#### Primary Practice/Position Area:

- Urban, inner city  Urban, non-inner city  Suburban  
 Rural  Other \_\_\_\_\_

#### Size of Institution:

- Fewer than 99 Beds  100-199 Beds  200-299 Beds  
 300-399 Beds  400+ Beds  Not Applicable

#### Ethnic/Cultural Group:

- African-American/Black  Asian or Pacific Islander  
 Hispanic  Native American/Alaskan Native  
 White, Non-Hispanic  Other \_\_\_\_\_

#### Primary Language:

- Arabic  Chinese (Mandarin)  English  
 French  German  Japanese  Spanish  
 Other \_\_\_\_\_

#### How did you learn about the Society of Critical Care Medicine?: (Please check one)

- SCCM Congress  *Critical Care Medicine* journal  
 *Critical Connections*  Internet  Friend or Colleague  
 Direct Mail  Other \_\_\_\_\_

**Check here if you are interested in volunteer opportunities with the Society of Critical Care Medicine.**

### Payment Information:

\_\_\_\_\_ **Annual Dues**

\_\_\_\_\_ Add \$55 if Pediatric Section membership selected.

\_\_\_\_\_ Add \$45 if Chapter membership selected.

**Total Enclosed \$** \_\_\_\_\_

**Check** made payable to Society of Critical Care Medicine (U.S. funds drawn on U.S. bank) or **International Money Order**

**Credit Card**  Visa  MasterCard  American Express  Discover

\_\_\_\_\_  
Card Number \_\_\_\_\_  
Exp. Date

\_\_\_\_\_  
Cardholder Name

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

**Return this form along with payment to: 35083 Eagle Way, Chicago, IL 60678-1350. Or fax to: (847) 827-7913.**

## Distinguish yourself.

Join the Society of Critical Care Medicine today!