

SCCM Chapter Membership Application

Choose from 3 easy ways to join a chapter:

- 1 Call SCCM Customer Service at +1 847 827-6888
- 2 Fax the completed chapter membership application to +1 847 439-7226
- 3 Mail the completed chapter membership application along with payment to: SCCM, 35083 Eagle Way, Chicago, IL 60678-1350 USA

Chapters provide a vehicle for members to exchange information, network with local critical care practitioners, and discuss the impact of national issues on their communities. If you are not a member of SCCM and would like to join both the national society and a local chapter, please visit sccm.org/join to fill out an SCCM membership application.

Personal Information (Please Print)

Prefix _____ First Name _____ Middle Initial _____ Last Name (Surname) _____ Designation (MD, RN, PharmD, etc.) _____ Profession _____
Institution Name _____ Title _____

Address

Office Number/Street/Suite Preferred _____ City/State/Province _____ Zip Code/Postal Code _____ Country _____
Home Number/Street/Unit Preferred _____ City/State/Province _____ Zip Code/Postal Code _____ Country _____

Phone/E-mail

Business Phone Number Preferred _____ Business E-mail Preferred _____
Home Phone Number Preferred _____ Home E-mail Preferred _____

Certifications

Board Certification(s)/License(s) & Year: _____ Subspecialty Board Certification & Year: _____

Chapter Membership Fees

The fee for full chapter membership is \$45 U.S. Chapter membership is free for Sponsored Fellows. Please indicate which membership category applies to you and select which chapter you would like to join.

- Full membership Sponsored Fellows Membership

Chapters

- | | | |
|---|--|--|
| <input type="radio"/> Baltimore | <input type="radio"/> Northeast (CT, MA, ME, NH, NY, RI, VT) | <input type="radio"/> Pennsylvania |
| <input type="radio"/> Carolinas/Virginia (NC, SC, VA, WV) | <input type="radio"/> Northern California | <input type="radio"/> Southeast (AL, AR, GA, KY, LA, MS, TN) |
| <input type="radio"/> Florida | <input type="radio"/> North Central (IA, MN, ND, SD, WI) | <input type="radio"/> Southern California |
| <input type="radio"/> New Jersey | <input type="radio"/> Ohio | <input type="radio"/> Texas |
| <input type="radio"/> New Mexico | <input type="radio"/> Oregon | |

Demographic

Primary Employment Setting

- Government hospital/clinic
 Medical school/university
 Non-government hospital/clinic
 Pediatric/multispecialty group practice
 Solo/two-physician practice
 Staff model HMO
 Other: _____

Primary Practice/Position Area

- Military
 Rural
 Suburban
 Urban, inner city
 Urban, non-inner city
 Other: _____

Ethnic/Cultural Group

- African American/Black
 Asian/Pacific Islander
 Hispanic
 Native American/Native Alaskan
 White/Non-Hispanic
 Other: _____

Gender

- Male
 Female

Date of Birth MM/DD/YYYY _____

Payment Information

_____ Chapter Dues

Charge to: American Express Discover MasterCard Visa

Total Enclosed \$ _____ USD

Card Number _____ Expiration Date _____

- Check made payable to Society of Critical Care Medicine (U.S. funds drawn on U.S. bank) or international money order

Cardholder Name _____

Signature _____

Date _____