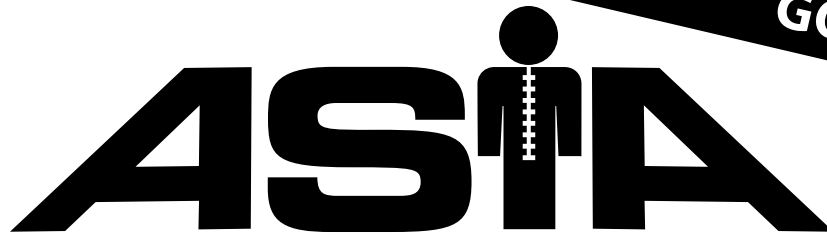


GOLD LEVEL



AMERICAN SPINAL INJURY ASSOCIATION

CLINIC/INSTITUTION MEMBERSHIP APPLICATION

Please print or type **Address will be available in member directory unless box is checked.**

Clinic/Institution Name _____

Address _____

City _____ State _____ Country _____ Zip/Postal Code _____

Primary Contact _____ Title _____

E-Mail _____ Office Phone _____

** Email is required to receive future membership information Please print clearly for successful email delivery.*

\$3,000 Annually - Gold Level

ANNUAL CLINIC/INSTITUTION MEMBERSHIP BENEFITS	\$5,000 FEE INCLUDES
MD/PhD/DO Memberships	Up to two
Allied Health Memberships	Up to two
Annual Meeting Registration fees waived	Up to two
Ads/Announcements in bulletins and newsletter	Up to two
Institutional banner and link on the ASIA website	✓
Hospital logo and/or ad in Annual Meeting Program	✓
Job announcement on job board for one year	✓

PAYMENT OPTIONS

Check or money order enclosed (US Funds) made payable to: ASIA

If paying by check, you MUST include a copy of this application with your payment.

AmEx Mastercard Visa Discover Name on Card: _____

Expiration Date: _____ Card Number: _____ CVV Security Code* _____

Signature: _____ Date: _____

**CVV code is the three-digit number on the back of VISA, MC or Discover or four-digit number on the front of AMEX card above the account number.*

AMERICAN SPINAL INJURY ASSOCIATION

2209 Dickens Road • Richmond, VA 23230-2005 • (804) 565-6396 • Fax (804) 282-0090
asia.office@asia-spinalinjury.org • www.asia-spinalinjury.org



CLINIC/INSTITUTION MEMBERSHIP GROUP FORM

Please complete this form, indicating the participants in your Clinic/Institution Membership. Clinic/Institution memberships are granted up to three MD/PhD memberships and up to three Allied Health memberships.

Please return all completed forms to:
ASIA, Attention: Greg Leasure, 2209 Dickens Road, Richmond, VA 23230-2005,
via email to greg@societyhq.com or by fax (804) 282-0090.

Please print or type

Address will be available in member directory unless box is checked.

Clinic/Institution Name _____

Primary Contact _____ Title _____

MD/PhD Participant Names:

Name _____ Email Address _____

Name _____ Email Address _____

Allied Health Participant Names:

Name _____ Email Address _____

Name _____ Email Address _____

Current individual ASIA members do not need to complete individual membership applications.

If you do not receive a confirmation e-mail from the ASIA office within 30 days of submitting your registration form, please call the office to confirm that your registration material has been received.



CLINIC/INSTITUTION INDIVIDUAL MEMBERSHIP APPLICATION

Please complete this application if you are **NOT** a current ASIA member.

Please print or type **Address will be available in member directory unless box is checked.**

MEMBERSHIP CLASS APPLYING FOR: MD/PhD/DO Allied Health **I AM:** Male Female

Last Name _____ First Name _____ MI _____ Degree/Title _____

PREFERRED MAILING/BILLING ADDRESS: Home Work

Home Address _____

Address: _____

City: _____ State: _____ Country: _____ Zip/Postal Code: _____

Primary Phone: _____ Secondary (private) Phone: _____

E-Mail: _____ Date of Birth (mm/dd/yyyy): ____/____/____

Race/Ethnicity (Optional) (*Race and Ethnicity information is used for federal grant application purposes only.*) American Indian/Alaska Native Asian

Black/African American Hispanic/Latino Native Hawaiian/Pacific Islander White/Caucasian Choose not to answer

Hospital/Institution/Practice _____

Address _____

City _____ State: _____ Country: _____ Zip/Postal Code: _____

Phone _____ Fax _____

E-Mail _____ Date of Birth (mm/dd/yyyy) ____/____/____

*** Email is required to receive future membership information Please print clearly for successful email delivery.**

EDUCATION

Discipline/Degree: (check all that apply) PhD MD/DO/MBBS Nursing PT/DPT OT SLP SW
 Psych ACP (PA/NP) RCSP CTRS Administration Researcher Other _____

Highest Degree Obtained: (check all that apply) MD/DO PhD Other Doctorate degree _____
 Master's Degree Bachelor's Degree

What is your area of interest and role related to the field of Spinal Cord Injury? (check all that apply)
 Acute Care (Emergent/Critical Care) Advocacy Aging/Geriatrics Autonomic Systems Basic Science
 Biomedical Research/Biomedical Engineering Clinical Trials/Research Health and Wellness/Prevention
 Health Care Administration/Health Care Policy Medical-Legal Mental Health Pain Management Pediatrics
 Primary care Public Health Rehabilitation Rehabilitation Counseling Respiratory Therapy/Pulmonary Care
 Social Media Social Work/Community Based Practice/Care Management Technology Translational Science
 Vocational Rehabilitation

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