ASIA

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.***

$5,000 Annually

ANNUAL CLINIC/INSTITUTION MEMBERSHIP BENEFITS	$5,000 FEE INCLUDES
MD/PhD Memberships	Up to three
Allied Health Memberships	Up to three
Annual Meeting Registrations	Up to three
Ads/Announcements in bulletins and newsletter	Up to four
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@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 ______________

Name ______________________ Email Address ______________

Allied Health Participant Names:

Name ______________________ Email Address ______________

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 SABM office within 30 days of submitting your registration form, please call the office to confirm that your registration material has been received.

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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 ❑ 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): _____ /_____ /_____

Hospital/Institution/Practice ____

Address ____

City ______________________ State: _____ Country: __________ Zip/Postal Code: ____________

Phone ______________________ Fax ______________________

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

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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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