PLATINUM 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.***

$5,000 Annually – Platinum Level

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	✓
eLearning Registrations	Up to five

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

AMERICAN SPINAL INJURY ASSOCIATION

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 ASIA 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/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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