# Membership Application
## The American Society of Hypothermic Medicine

Please Complete Form and Mail, Email, or Fax to:

The American Society of Hypothermic Medicine
901 S Oregon Avenue, Tampa, FL 33606

Fax: (813) 875-4149
hypothermicmedicine@hotmail.com

## General Information

_____ _____ _____ _____ _____
Prefix First Name Middle Initial Last Name Suffix

_____ _____
Professional Degree(s): MD, DO, PhD, RN, etc.

### Home Mailing Address

_____
Street Address

_____ _____
City, State/Province Zip Code

_____ _____
Phone Cell Phone

_____ _____
Fax Email Address

Preferred mailing address? ___ Home ___ Employer
Preferred Facsimile number? ___ Home ___ Employer
Preferred e-mail address? ___ Home ___ Employer

### Employer Mailing Address

_____
Business Name

_____
Job Title/Department

_____
Street Address

_____ _____
City, State/Province Zip Code

_____ _____
Phone Cell Phone

_____ _____
Fax Email Address

## Membership Category: (select one)

___ Physician/Scientist Member - $250 Annual Dues
___ Fellow/Resident/Student - $150 Annual Dues,
verification letter from program director is required
___ CEO/Non-Physician Administrator Member - $200 Annual Dues
___ Physician Assistant Member - $100 Annual Dues
___ Nurse Member - $100 Annual Dues
___ Emergency Medical Technician - $100 Annual Dues
___ Technologist Member - $100 Annual Dues
___ Associate Member - $100 Annual Dues

# Professional Information

## Primary Specialty: (select one)

___ Cardiology
___ Cardiothoracic Surgery
___ Critical Care
___ Emergency Medicine
___ General Medicine
___ General Surgery
___ Internal Medicine
___ Neurology
___ Neurological Surgery
___ Orthopedic Surgery
___ Pediatric Medicine
___ Pediatric Surgery
___ Physical Medicine and Rehabilitation
___ Trauma Surgery
___ Other: _____

## Responsibilities presently engaged in: (select all that apply)

___ Administration or Management
___ Hospital
___ Internal Medicine
___ Military
___ Pediatrics
___ Physician
___ Private Practice
___ Research
___ Scientist
___ Teaching
___ University
___ Other: _____

Would you be interested in Registry? __ Yes __ No
Are you currently performing Therapeutic Hypothermia?
___ Yes ___ No
If so, for how long? _____

# Payment Options

___ Enclosed is a check (USD) made payable to ASHM for first-year dues
___ Credit Card Information is as follows:

Credit Card: __ Visa __ MasterCard __ American Express
__ Discovery

_____ _____ _____
Card Number Exp Date CVV Code

_____ _____ _____
Signature Date

Credit Card Address: __ use Home __ use Employer __ use below:

_____ _____

_____ _____

# Membership Agreement

As a member of The American Society of Hypothermic Medicine, Inc., I pledge to uphold the highest standards of care in use of Therapeutic Hypothermia. I fully understand that any misconduct on my part, including behavior that is unethical or detrimental to the purposes of this Corporation will result in cancellation of my membership, as described in the Corporation Bylaws.

_____ _____ _____
Signature Date