Membership Application
The American Society of Hypothermic Medicine

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

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
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 _____________