ASNC Membership Application For Practice Administrators

For faster processing apply at www.asnc.org/joinasnc. Application must be fully completed, enter “N/A” in non-applicable fields.

FULL NAME: (As you would like it to appear on your ASNC Membership Certificate)

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<th>MIDDLE NAME OR INITIAL</th>
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PREFERRED MAILING ADDRESS: □Work  □Home (Check one) Please note that ASNC does not sell phone numbers or e-mail addresses.

ADDRESS TO LIST IN MEMBERSHIP DIRECTORY: □WORK □HOME □NONE (Check one)

COMPANY NAME / DEPARTMENT

WORK STREET ADDRESS

CITY
STATE
COUNTRY
ZIP/POSTAL CODE

PHONE
FAX
E-MAIL (required)

HOME STREET ADDRESS

CITY
STATE
COUNTRY
ZIP/POSTAL CODE

GENDER: □MALE □FEMALE

DATE OF BIRTH: _____/_____/_____

PROFESSIONAL WORK SETTING:
□Solo Practice  □Group Practice  □Hospital  □Academic  □Industry  □Other: ________________

PRACTICE MEDICAL SPECIALTY: (Check one)
□Nuclear Cardiology □General Cardiology □Nuclear Medicine □Echocardiography □Radiology □CT Cardiology □MR Cardiology □Other: ________________

EDUCATION: (Required for ALL applicants. Please list highest degree.)

NAME OF INSTITUTION
CITY
COUNTRY
GRADUATION DATE
DEGREE
SUBJECT(S)

MEDICAL SOCIETY MEMBERSHIPS: (e.g. ACC, AMA, ASE, SNMMI, etc.)

______________________________________________________________

PERSONAL SIGNATURE OF APPLICANT (required) __________________________ DATE __/__/____

PAYMENT INFORMATION: □MedAxiom Member ($75)*with verification □Non-MedAxiom Member ($100)

Please charge my: □Visa □MasterCard □American Express
Check Enclosed (in USD only): □Personal #: __________________ □Company #: __________________

CARD NUMBER
EXPIRATION DATE
SECURITY CODE (3/4 DIGIT CODE)

PRINTED NAME ON CARD
CARDHOLDER SIGNATURE