

Referring Member

Name _____

Member ID _____



The VOICE for the Vascular Ultrasound Profession since 1977

SVU MEMBERSHIP APPLICATION

Please type or print

Mr. Mrs. Ms. Dr. Name _____

Job Title _____

Preferred Mailing Address: Business Home

Company/Institution _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

E-mail _____

Billing Address for credit card charges (if different from address above)

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

E-mail _____

Dues (effective until 12/31/2014)

Note: Approximately 20% of your membership dues will be used for advocacy expenses.

Physician Membership (USA/International)..... \$245/yr

Regular Membership (USA & Canada) \$145/yr

International Membership (outside USA & Canada) \$150/yr

Resident/Fellows Membership..... \$95/yr

Resident/Fellows rate is for physicians training at an accredited hospital. ALL are required to submit proof of status in the form of a letter from their department head or program director.

Student..... \$25/yr

Students must be full time undergraduate or graduate students and must submit a letter from the department head or registrar certifying your current student status and date of graduation.

Student Transitional Membership \$60/yr

Previously enrolled SVU Student Members for first year after graduation.

Retired/Disabled Member \$45/yr

Retired from active employment and no longer employed and/or permanently disabled. Visit online for details and required affidavit.

Payment method

Please make checks payable to SVU in US funds drawn on a US bank, net of all bank charges, or use a credit card: MasterCard Visa AmEx

Account No. _____ Exp. Date _____

Signature _____

Print name _____

Mail this form to:

SVU, P.O. Box 75491
Baltimore, MD 21275-5491

Or fax to (credit card payment only):
301-459-5651

For more information

Phone: 301-459-7550 or 800-SVU-VEIN
E-mail: svuinfo@svunet.org

Or visit us on the web at www.svunet.org

Certification(s) by professional certifying board or agency:

- RVT RDMS RDCS RVS RPVI
- RPhS RN CVN LPN LVN RT
- RPhS RTR CRT RRT PA-C
- Other: _____

Highest Degree earned:

- High School Some College
- Diploma Program AS AA BS
- BA BSN MS MA MSN
- Med MBA MD DO PhD
- ScD JD Other: _____

Work setting (check one):

- Hospital/Institution
- Private Lab/Physician's Office
- Equipment Company

Other organizations of which you are a member:

- SDMS SVS SVM ASE ACP
- ASN ACC SIR SVN ACR
- ASRT Other: _____

Year you began work in a noninvasive field:

Specialty of the Physician Medical Director (check one):

- Vascular Surgery Cardiology
- Cardiovascular Surgery
- Radiology Neurology
- General Surgery
- Other: _____

Is the performance of noninvasive vascular testing your primary job responsibility?

- Yes No

If not, describe your primary job responsibility:

If you are a member of an affiliated SVU Chapter, specify chapter:

Promotion Code: _____