

# Application for Educational Membership

## PERSONAL INFORMATION (Please print or type)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Full Legal Name)

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ Suite No: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

\*E-mail: \_\_\_\_\_  Do Not Display

\*Tel: \_\_\_\_\_  Do Not Display \*Fax: \_\_\_\_\_  Do Not Display

\*Unless indicated in the "Do Not Display" box, this information will be included in your online directory listing that can be viewed by other ASA members.

Please select:  AA-C  CRNA  Dentist  Veterinarian

Training Program: \_\_\_\_\_

Current Appointment: \_\_\_\_\_ Suite No: \_\_\_\_\_

I agree with the "Guidelines for the Ethical Practice of Anesthesiology" and subscribe to the "Anesthesia Care Team" statement, as provided with this application.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PAYMENT METHOD (Payment must accompany application to be processed)

\$315 Annual Dues  \$157.50 after June 30<sup>th</sup>

American Express  MasterCard  VISA  Check (Payable to American Society of Anesthesiologists)

Total Amount: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Card ID: \_\_\_\_\_

Signature: \_\_\_\_\_

**Mail payment and completed form to:**  
American Society of Anesthesiologists  
Attn: Membership  
520 N. Northwest Highway  
Park Ridge, IL 60068-2573

**Or fax to:**  
Attn: Membership  
(847) 825-1692