

## APPLICATION FOR MEDICAL STUDENT MEMBERSHIP

*Please type or print legibly*

1. Name \_\_\_\_\_  
First
Middle/Maiden
Last

Male       Female

2. List *both* home and office addresses, and check your *preferred mailing* address.

**Home**

**Institution\***

\_\_\_\_\_  
Address

\_\_\_\_\_  
Institution

\_\_\_\_\_  
City                      State                      Zip

\_\_\_\_\_  
Address

\_\_\_\_\_  
Country

\_\_\_\_\_  
City                      State                      Zip

Phone: \_\_\_\_\_

\_\_\_\_\_  
Country

E-Mail \_\_\_\_\_

Phone: \_\_\_\_\_

FAX: \_\_\_\_\_

E-Mail \_\_\_\_\_

Website: \_\_\_\_\_

3. Medical Student Program:

\_\_\_\_\_  
Title of Department/Division

\_\_\_\_\_  
Date of Enrollment

\_\_\_\_\_  
Proposed Date of Graduation

\_\_\_\_\_  
Name of Dean/Surgery Department Chair (Please Print)

\_\_\_\_\_  
Signature of Dean/Surgery Department Chair

Office Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

4. I agree to abide by the Bylaws of the SNIS and any revisions thereof:

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

I hereby certify that all information recorded on this application and any attached documents are accurate and support my qualifications for membership with SNIS for which I now apply.

\_\_\_ Check enclosed (make payable to SNIS) in the amount of \$25.00 USD

\_\_\_ Please charge my: \_\_\_ Visa \_\_\_ Master Card \_\_\_ Discover Card \_\_\_ Amex in the amount of \$25.00 USD

\*\*If paying by credit card, please list your 3-digit (AMEX 4-digit) security code from the signature strip: \_\_\_\_\_\*\*

Card Holder Name: \_\_\_\_\_

Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

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

### **IMPORTANT!!**

**If the Society learns that any information in your application is untrue, or if circumstances change after the date of application that affects ethical and professional standards, it may be grounds for suspension or revocation of membership. The Society of NeuroInterventional Surgery does not adopt any practice, policy, or procedure which would result in discrimination on the basis of race, religion, creed or health status for membership. Cancellation of membership must be submitted in writing and cannot be granted retroactively.**

### **Medical Student Membership Documentation Required**

- *Completed application;*
- *Include the membership payment in the form of credit card or check;*

\* Name, address, telephone, fax and e-mail information will appear in the SNIS online directory. Please refer to the *Medical Student Membership Information* sheet accompanying this application for full details.

**PLEASE RETURN COMPLETED APPLICATION TO:**

**SNIS Membership Chairman  
3975 Fair Ridge Drive, Suite 460 South  
Fairfax, VA 22033**