Application for Active Membership

- Doctoral, Physician ($310)
- Professional Health Care ($195)
- Trainee, Physician in Training ($170)
- Doctoral, Other ($195)
- Professional, Other ($195)
- Trainee, Other Student or Trainee ($70)

See Membership Categories in this flyer for category criteria. A letter from the trainee’s institutional program director will be required as part of the trainee membership application and should be sent to the offices of the ASNR. The membership year runs from January to December and dues paid in October, November or December will be applied to the following year. Dues amounts are subject to change at the discretion of the Board of ASNR and would become effective at the beginning of the fiscal year.

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<tr>
<th>Name (First)</th>
<th>(MI)</th>
<th>(Last)</th>
<th>(Degree)</th>
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Institutional Affiliation

Institution Mailing Address

Street

City, State, Zip

Preferred mailing address (if different from Institution Mailing address)

Street

City, State, Zip

Phone Fax Email

Date of Birth Male Female

Activities List

- Advocacy
- Basic Neuroscience Research
- Biomedical Engineering
- Clinical Trials
- Critical Care
- Geriatrics
- Human Neuroscience Research
- Internal Medicine
- Neurology
- Neurosurgery
- Nursing
- Occupational Therapy
- Orthopedics
- Other Rehabilitation Research
- Pediatrics
- Physical Therapy
- Psychiatry
- Psychology
- Recreational Therapy
- Social Work
- Speech/Language Therapy
- Trauma
- Urology

Please continue application on back
## Education

### Undergraduate

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<th>Institution</th>
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### Medical/Graduate

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### Residency

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### Fellowships

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<th>Institution</th>
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### Board Subspecialty Certification

______________________________

### Medical or Professional Societies/Honors

______________________________

### How did you hear about the ASNR? (Please include name of referring member if applicable)

______________________________

## Payment Information

*I authorize the American Society of Neurorehabilitation to charge my dues to my credit card listed below.*

**TOTAL AMOUNT ENCLOSED $** ________________

- [ ] Check/Money order (US funds)  Check # ________________________________
- [ ] Visa  Card # ________________________________ Exp. Date ___________
- [ ] Master Card  Card # ________________________________

Name as it appears on card ________________________________

Signature ________________________________

*A $25 processing fee will be charged for declined charges or returned checks.*

## Verification of Information

*I hereby certify that the information furnished is true and correct and that the ASNR is authorized to investigate and verify any representation made on this application.*

Signature ________________________________  Date _________________________

Please ensure all supporting documentation is included and mail or fax to:

5841 Cedar Lake Road  Phone (952) 545-6324
Suite 204  Fax (952) 545-6073
Minneapolis, MN  55416  Email info@asnr.com
www.asnr.com