

Application for Active Membership

- Active Physician - \$260
- Active Non-Physician - \$185
- Physician in Training - \$160
- Student - \$60

Active Membership category includes all health care professionals, scientists and engineers interested in neurorehabilitation and promoting the Society's goals. This category of membership includes physician and non-physician rehabilitation specialists and investigators.

Physician in Training category includes residents and fellows. A letter from the Program Director of an institution accredited by the Accreditation Council for Graduate Medical Education (ACGME) will be required as part of the member application.

Student category includes individuals with documented matriculation in a medical, rehabilitation services (OT, PT, Speech) or neurosciences research program. A letter from the Dean's office of the program or a current transcript are required as part of the member application. The undergraduate programs must have established majors in the neurosciences.

PLEASE NOTE: The membership year runs from January to December.
Applications received in October, November and December will be applied to the next membership year.
Dues amounts are subject to change at the discretion of the Society and will be effective at the beginning of the fiscal year.

Name (First) _____ (MI) _____ (Last) _____ (Degree) _____

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 _____

Online journal subscriptions cannot be provided without an email address

Date of Birth _____ Male Female

Professional Specialty

- Physician
- Psychologist
- Physical Therapist
- Occupational Therapist
- Speech/Language Pathologist
- Rehabilitation Nurse
- Social Worker
- Researcher
- Other _____

Please continue application on back

Education

Undergraduate

	<i>Institution</i>	<i>Dates</i>	<i>Degree</i>
Medical/Graduate/Residency			
	<i>Institution</i>	<i>Dates</i>	<i>Degree</i>
	<i>Institution</i>	<i>Dates</i>	<i>Degree</i>
	<i>Institution</i>	<i>Dates</i>	<i>Degree</i>

Medical or Professional Memberships and 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 Master Card Card # _____ Exp. Date _____

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:



AMERICAN SOCIETY OF
NEUROREHABILITATION
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Suite 204
Minneapolis, MN 55416

Phone (952) 545-6324
Fax (952) 545-6073
Email asnr@llmsi.com
Website www.asnr.com