



Application for Membership in

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

1209 Montgomery Highway, Birmingham, Alabama 35216-2809

Telephone (205) 978-5000 • Fax (205) 978-5018 • Email asrm@asrm.org • www.asrm.org

Check # _____ Amount \$ _____

Account # _____

Date of Membership: _____

(For ASRM office use only)

PLEASE TYPE OR PRINT CLEARLY.

GENDER (Please circle one): MALE FEMALE

LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS

CITY/PROVINCE STATE COUNTRY ZIP/POSTAL CODE

()

TELEPHONE FAX NUMBER

DOB (MO DAY YEAR) EMAIL ADDRESS WEBSITE

SPECIALTY (PLEASE CHECK ONLY ONE.)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Administrative | <input type="checkbox"/> Gynecology | <input type="checkbox"/> Nurse | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Andrology | <input type="checkbox"/> Infertility Only | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Embryology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> REI (ABOG Certified or Candidate Only) | <input type="checkbox"/> Veterinary Medicine |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Resident/Fellow | <input type="checkbox"/> Other (SPECIFY) |
| <input type="checkbox"/> Genetic Counselor | <input type="checkbox"/> Mental Health Professional | <input type="checkbox"/> Research | |

EDUCATION

UNIVERSITY/COLLEGE DEGREE DATE

LIST OTHER DEGREES WITH DATES

RESIDENCY SPECIALTY INSTITUTION DATE

FELLOWSHIP SUB-SPECIALTY INSTITUTION DATE

HOSPITAL AFFILIATION(S)

OTHER PROFESSIONAL SOCIETIES

CERTIFIED BY (SPECIALTY BOARD) DATE

CERTIFIED BY (SUB-SPECIALTY BOARD) DATE

I ATTEST THAT ALL OF THE INFORMATION STATED ON THIS FORM IS CORRECT.

AMA MEMBER YES NO
ACOG MEMBER YES NO

SIGNATURE DATE

MEMBERSHIP

- | | |
|--|--|
| <input type="checkbox"/> Physician: \$250 | <input type="checkbox"/> Non-Ph.D. Lab Personnel: \$125 |
| <input type="checkbox"/> Ph.D.: \$250 | <input type="checkbox"/> Administrator: \$125 |
| <input type="checkbox"/> Other Doctorate - L.L.D., J.D., D.V.M., etc.: \$250 | <input type="checkbox"/> Medical Student/Graduate Student/Resident/Fellow: \$125 |
| <input type="checkbox"/> Allied Health Professional: \$125 | |

SPECIAL INTEREST GROUPS (SIG) (PLEASE CHECK ALL YOU WISH TO JOIN.)

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Androgen Excess | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Genetic Counseling | <input type="checkbox"/> Pediatric & Adolescent Gynecology | <input type="checkbox"/> Sexuality |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Environment & Reproduction | <input type="checkbox"/> Imaging | <input type="checkbox"/> PGD | <input type="checkbox"/> Women's Council |
| <input type="checkbox"/> Contraception | <input type="checkbox"/> Fertility Preservation | <input type="checkbox"/> Menopause | <input type="checkbox"/> Reproductive Immunology (\$10 fee) | |

PROFESSIONAL GROUPS (PG) (PLEASE CHECK ALL YOU WISH TO JOIN.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Association of Reproductive Managers | <input type="checkbox"/> Nurses | <input type="checkbox"/> Reproductive Laboratory Technologists |
| <input type="checkbox"/> Mental Health (\$10 fee) | <input type="checkbox"/> Reproductive Biologists | |

AFFILIATED SOCIETIES (PLEASE CHECK ALL YOU WISH TO JOIN.)

- | | |
|---|--|
| <input type="checkbox"/> The Society for Reproductive Endocrinology & Infertility* (Active: \$90 fee + \$15 endowment; Medical Student/Resident/Postdoctoral Fellow: \$25 fee + \$15 endowment) | <input type="checkbox"/> The Society for Male Reproduction & Urology (Active: \$75 fee + \$15 endowment; Medical Student/Resident/Postdoctoral Fellow: \$35 fee) |
| <input type="checkbox"/> The Society of Reproductive Surgeons (Active: \$75 fee; Medical Student/Resident/Postdoctoral Fellow: \$25 fee) | |

Member Dues:\$ _____ + SIG Dues:\$ _____ + PG Dues:\$ _____ + Affiliate Dues:\$ _____ = Total Amount Owed \$ _____

Please attach a check or pay by credit card. International members may remit payment in U.S. funds only, via check/draft drawn on a U.S. bank, or pay by credit card. I am paying by (please check one): VISA Mastercard American Express Check # _____

BILLING ADDRESS(Address where your credit card bill comes.)

CARD NUMBER EXPIRATION DATE

CARDHOLDER SIGNATURE (Required, authorizing charge.) NAME AS IT APPEARS ON CARD (Please print.)

The ASRM reserves the right to charge the correct amount if different from the total payment listed above.

*Must be a Board Certified Reproductive Endocrinologist or a Fellow/Candidate for REI Certification.