# SHSMD today.
# Career advancement tomorrow.

Take advantage of all SHSMD has to offer. Join today by completing this application, or join online at shsmd.org/join. If you have questions, contact us at shsmd@aha.org.

**Member Information** (all fields required)

Name

Title

Organization

**I prefer to have my mail sent to:** ❑ Business address ❑ Home address

Street address

City | State | Zip

Telephone | Fax

Email address

**Annual member dues**

❑ Member from a health care provider organization - $235 ❑ Consultant member - $235

❑ Vendor member - $235 ❑ Faculty member - $105 ❑ Student member - $85

**Method of payment**

❑ Check or money order made payable to: AHA/SHSMD.

❑ Visa ❑ MasterCard ❑ American Express

Name of cardholder

Card number

Expiration date

Cardholder's signature

**To submit this application**

Mail: AHA/SHSMD | PO Box 75315 | Chicago, IL 60675-5315

Fax: (312) 276-8015 Call: (312) 422-3888 shsmd.org/join

**Thank you! We look forward to welcoming you into the SHSMD community.**