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 □ 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) 422-3609   Call: (312) 422-3888   shsmd.org/join

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