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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

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

Card number

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To submit this application

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