



**AMERICAN CLINICAL NEUROPHYSIOLOGY SOCIETY
APPLICATION FOR MEMBERSHIP**

MEMBER TYPE (Please check one.)

Regular Member / \$400

Individuals who have obtained a MD, DO, or PhD degree or are credentialed by ABRET or the equivalent

Please check below to apply for one of the following discounted dues categories for Regular Members:

Non-Physician / **\$325**

Early Practice (The first two years after graduating from a training program) / **\$150**

Resident of World Bank "High-Income Economy" Country (excluding the United States and Canada) / **\$165**

Resident of World Bank "Upper-Middle-Income" Country / **\$125**

Junior Member / \$120

Training Completion Date: _____

Individuals in clinical neurophysiology or related fields who are in pre-doctoral or postdoctoral training; limited to a period of three (3) years.

Associate Member / \$300

Individuals who have an interest in clinical neurophysiology or related fields.

CONTACT/DIRECTORY INFORMATION (please check your preferred mailing and billing address)

Business

Home

First (Given) Name: _____ Middle Initial: _____ Last (Family) Name: _____

Degree: _____ Institution: _____

Present Position or Title: _____

Business Address:

| | | |
|-----------------|---------------|-------------|
| Address: | | |
| | | |
| City: | State: | Zip: |
| Country: | | |
| Phone: | Fax: | |
| Email: | | |

Home Address:

| | | |
|-----------------|---------------|-------------|
| Address: | | |
| | | |
| City: | State: | Zip: |
| Country: | | |
| Phone: | Fax: | |
| Email: | | |

EDUCATION (e.g. MD, PhD)

| University/Institution | Degree Achieved | End Year |
|------------------------|-----------------|----------|
| | | |

PROFESSIONAL TRAINING (e.g. Residency, Fellowship)

| University/Institution | Training Type | Start Year | End Year |
|------------------------|---------------|------------|----------|
| | | | |

CREDENTIALS/CERTIFICATIONS

AMA Member Yes No AMA Member # _____

American Board of Clinical Neurophysiology Yes No

Other Specialty or Subspecialty Certification: _____

ACNS CODE OF MEMBER CONDUCT

I agree to abide by the ACNS Code of Member Conduct. Full conduct document can be found at <https://www.acns.org>.

ACNS DATA PRIVACY POLICY CONDUCT

I agree to the ACNS data privacy policy. Full policy can be found at <https://www.acns.org/privacy-policy>.

PAYMENT INFORMATION

Applications must be accompanied by an application fee in the amount of the dues amount indicated above. Upon approval, the application fee will be credited toward the member's first year of dues. If the application is denied, application fees will be refunded in full.

Company Check – Make check payable to American Clinical Neurophysiology Society (in US Dollars, drawn on a US bank)

Credit Card (check one)

VISA

MasterCard

Discover

Card Number: _____ Expiration Date: _____

Card Holder Name: _____

Card Holder Signature: _____

Please return this application via email, fax or mail:

American Clinical Neurophysiology Society

555 E. Wells Street, Suite 1100 Milwaukee, WI 53202

Phone: 414-918-9803 | Fax: 414-276-3349 | info@acns.org