MEMBERSHIP APPLICATION - SOLAS MEMBERS

Personal Information

Name: First/Middle/Last

Degree(s)

Date of Birth

Year of Residency Completion or Expected Completion

Board Certification/Eligibility

Institution

Street Address

City/State/Province

Postal Code/Country

Work Phone

Email Address

Specialty ☐ **Orthopaedic Surgery** ☐ **Neurosurgery** ☐ **Other (Please specify)**

Membership Categories *Please select your membership category.*

SMISS One-Year Membership	US Dollars
Surgeon	**$295**
Resident/Fellow	**$100**
Allied Health Professional	**$150**

☐ **Surgeon** ☐ **Resident/Fellow** ☐ **Allied Health Professional**

Payment Information *Your first year of membership is **free.** You will not be charged today, but need to include payment information. Your membership will automatically renew one year from your join date.*

Check # (Checks must be made payable to SMISS. Only checks in USD drawn on US banks will be accepted.)

☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Discover**

Credit Card Number

Expiration Date **Verification Code**

Name as it Appears on Credit Card

Credit Card Billing Address

Signature **Date**

Please mail, email or fax completed application to:
Society for Minimally Invasive Spine Surgery
c/o BroadWater, 301 S. County Farm Road, Suite L, Wheaton, IL 60187 USA
T: 331-218-0780 F: 630-682-5811 E: membership@smiss.org