

## MEMBERSHIP APPLICATION

### Personal Information

<b>Name: First/Middle/Last</b>	<b>Institution</b>
<b>Credentials (MD, DO, PhD)</b>	<b>Street Address</b>
<b>Date of Birth</b>	<b>City/State/Province</b>
<b>Year Completed Residency</b>	<b>Postal Code/Country</b>
<b>Board Certification/Eligibility</b>	<b>Work Phone</b>
	<b>Email Address</b>
<b>Specialty</b>	<input type="checkbox"/> Orthopaedic Surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Other (Please specify)

### Membership Categories

SMISS One-Year Membership	US Dollars
Surgeon	\$395
Resident/Fellow	\$100
Allied Health Professional	\$150

Surgeon

Resident/Fellow

Allied Health Professional

### Payment Information

**Check #**  
(Please note: 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**