



**GOLD LEVEL**

## CLINIC/INSTITUTION MEMBERSHIP APPLICATION

**Please print or type**

**Address will be available in member directory unless box is checked. ☐**

Clinic/Institution Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Primary Contact \_\_\_\_\_ Title \_\_\_\_\_

E-Mail \_\_\_\_\_ Office Phone \_\_\_\_\_

**\* Email is required to receive future membership information Please print clearly for successful email delivery.**

### \$3,000 Annually - Gold Level

ANNUAL CLINIC/INSTITUTION MEMBERSHIP BENEFITS	\$5,000 FEE INCLUDES
MD/PhD/DO Memberships	Up to two
Allied Health Memberships	Up to two
Annual Meeting Registration fees waived	Up to two
Ads/Announcements in bulletins and newsletter	Up to two
Institutional banner and link on the ASIA website	✓
Hospital logo and/or ad in Annual Meeting Program	✓
Job announcement on job board for one year	✓

### PAYMENT OPTIONS

☐ Check or money order enclosed (US Funds) made payable to: ASIA

If paying by check, you MUST include a copy of this application with your payment.

☐ AmEx ☐ Mastercard ☐ Visa ☐ Discover Name on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Card Number: \_\_\_\_\_ CVV Security Code\* \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*CVV code is the three-digit number on the back of VISA, MC or Discover or four-digit number on the front of AMEX card above the account number.

Please send payment to:  
The American Spinal Injury Association  
9702 Gayton Rd, Suite 306, Richmond, VA 23238  
Payment is due 30 days from the date of the transaction.  
[www.asia-spinalinjury.org](http://www.asia-spinalinjury.org)



## CLINIC/INSTITUTION MEMBERSHIP GROUP FORM

**Please complete this form, indicating the participants in your Clinic/Institution Membership.  
Clinic/Institution memberships are granted up to three MD/PhD memberships and  
up to three Allied Health memberships.**

**Please return all completed forms to:  
ASIA, Attention: Greg Leasure, 2209 Dickens Road, Richmond, VA 23230-2005,  
via email to [greg@societyhq.com](mailto:greg@societyhq.com) or by fax (804) 282-0090.**

**Please print or type**

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Clinic/Institution Name \_\_\_\_\_

Primary Contact \_\_\_\_\_ Title \_\_\_\_\_

### **MD/PhD Participant Names:**

Name \_\_\_\_\_ Email Address \_\_\_\_\_

Name \_\_\_\_\_ Email Address \_\_\_\_\_

### **Allied Health Participant Names:**

Name \_\_\_\_\_ Email Address \_\_\_\_\_

Name \_\_\_\_\_ Email Address \_\_\_\_\_

**Current individual ASIA members do not need to complete individual membership applications.**

If you do not receive a confirmation e-mail from the ASIA office within 30 days of submitting your registration form, please call the office to confirm that your registration material has been received.

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## CLINIC/INSTITUTION INDIVIDUAL MEMBERSHIP APPLICATION

Please complete this application if you are **NOT** a current ASIA member.

Please print or type

Address will be available in member directory unless box is checked. ☐

**MEMBERSHIP CLASS APPLYING FOR:** ☐ MD/PhD/DO ☐ Allied Health **I AM:** ☐ Male ☐ Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Degree/Title \_\_\_\_\_

**PREFERRED MAILING/BILLING ADDRESS:** ☐ Home ☐ Work

Home Address \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary (private) Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital/Institution/Practice \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-Mail \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

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### EDUCATION

**Discipline/Degree:** (check all that apply) ☐ PhD ☐ MD/DO/MBBS ☐ Nursing ☐ PT/DPT ☐ OT ☐ SLP ☐ SW  
☐ Psych ☐ ACP (PA/NP) ☐ RCSP ☐ CTRS ☐ Administration ☐ Researcher ☐ Other \_\_\_\_\_

**Highest Degree Obtained:** (check all that apply) ☐ MD/DO ☐ PhD ☐ Other Doctorate degree \_\_\_\_\_  
☐ Master's Degree ☐ Bachelor's Degree

**What is your area of interest and role related to the field of Spinal Cord Injury?** (check all that apply)

☐ Acute Care (Emergent/Critical Care) ☐ Advocacy ☐ Aging/Geriatrics ☐ Autonomic Systems ☐ Basic Science  
☐ Biomedical Research/Biomedical Engineering ☐ Clinical Trials/Research ☐ Health and Wellness/Prevention  
☐ Health Care Administration/Health Care Policy ☐ Medical-Legal ☐ Mental Health ☐ Pain Management ☐ Pediatrics  
☐ Primary care ☐ Public Health ☐ Rehabilitation ☐ Rehabilitation Counseling ☐ Respiratory Therapy/Pulmonary Care  
☐ Social Media ☐ Social Work/Community Based Practice/Care Management ☐ Technology ☐ Translational Science  
☐ Vocational Rehabilitation

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