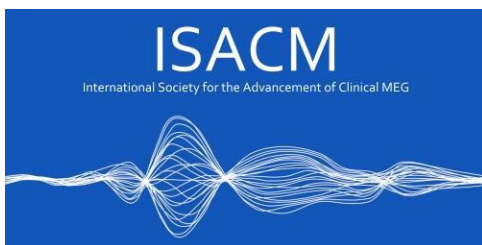


ISACM Membership Application/Renewal 2017-18 (Two Years)



Please send application to:
 ISACM – c/o Tim Roberts, Treasurer
 Children’s Hospital of Philadelphia
 Wood Bldg., Suite 2115
 34th St. & Civic Center Blvd.
 Philadelphia
 PA 19104
 USA, Phone 267 426 0307; **FAX 215 590 1345**

I am willing to be a candidate for ISACM Executive Committee membership 2017-2021

Last Name First/Given Name Middle Name _____

Gender: Male Female

Institute Contact Information:

Institute Name & Street Address _____

City and State/Province _____

Country and Postal Code _____

Telephone _____

Fax _____

Email _____

Honorific Professional Classification Primary Field Endeavor (check all that apply)

M.D. Basic Scientist BASIC SCIENCE CLINICAL SCIENCE

M.D. Candidate Clinical Scientist Biophysics Neurology

Ph.D. Educator Engineering Neurosurgery

Ph.D. Candidate Industrial Management Mathematics Radiology

Professor Physician Physics Psychiatry

RT Support Personnel Psychology Other: _____

Other: _____ Other: _____ Other: _____

If paying by check make payable to “ISACM” *All fees must be in US Dollars

Membership Dues for 2017 and 2018 US \$100.00 ; Students & Affiliates \$0 (non-voting membership)

To remit dues via credit card, please complete below (*All information below is required)

FAX to: 1-215-590-1345

Visa MasterCard American Express

Credit Card# _____ Expiration Date _____

Credit Card Signature _____ 3 or 4 digit Security Code _____

Billing Street Address _____

City/State _____ Zip/Postal Code _____

Country _____ Date _____

Applicant Signature _____