



Membership Application

Please print or type

Name: Mr. Ms. Miss Mrs. Dr.

First MI Last Designation (HT, HTL, RN, etc)

Gender: Male Female

Birthdate: _____
MM/DD/YYYY

Contact Information:

Office:
Facility Name: _____

Home:
Address: _____

Address: _____

Country: _____

Country: _____

Office phone: _____

Phone: _____

Office fax: _____

Email: _____

Email: _____

Send correspondence to:

Office address

Home address

ACMS Member affiliate surgeon (required for membership):

Physician Name (please print): _____

Exclude me from:

- Email communications
- Fax communications
- Text/SMS communications
- Online member directory

Membership Dues and Application Fee

Please indicate payment for current membership dues of \$175, plus a one-time \$25 application fee (\$200 total). Upon approval of your membership application, you will receive a dues receipt, as well as instructions on how to access the Members area of the ASMH website and access to the ASMH online newsletter and member directory.

JOIN ONLINE AT WWW.MOHSTECH.ORG/MEMBERSHIP | FAX: (414) 276-3349

Check enclosed

Mail to: ASMH Membership
555 East Wells Street, Suite 1100
Milwaukee, WI 53202

**2020 Dues Amount:
\$200.00**

MasterCard VISA American Express Discover

Card number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Expiration Date (MMYY):

--	--	--	--

Name of cardholder: _____

Cardholder signature: _____