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: ______________________

Address: ______________________

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Country: ______________________

Office phone: ______________________

Office fax: ______________________

Email: ______________________

Home:

Address: ______________________

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Country: ______________________

Phone: ______________________

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

2022 Dues Amount:
$200.00

☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Card number:

Expiration Date (MMYY):

Name of cardholder: ______________________

Cardholder signature: ______________________