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: _____
_____
Country: _____
Office phone: _____
Office fax: _____
Email: _____

Home:
Address: _____
_____
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 $225, plus a one-time $25 application fee ($250 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

2026 Dues Amount:
$250.00

☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Card number:

Expiration Date (MMYY):

Name of cardholder: _____

Cardholder signature: _____