

NEW MEMBER APPLICATION INSTITUTIONAL MEMBERSHIP

Please complete both sides of this application.

Institutional Membership is for hospitals and health care institutions, governmental, scientific, academic, philanthropic, and other non-profit organizations with an interest in medical instrumentation.

1 Complete Address Information

Please type or print your organization's name as it should appear in the online Membership Directory:

Name of Organization or Institution _____

Mailing Address _____

City _____ State/Province _____ Zip/Postal Code _____ Country _____

Phone _____ Fax _____ Web site Address _____

Please indicate your organization's primary business:

- | | |
|--|--|
| <input type="checkbox"/> Government Agency | <input type="checkbox"/> University |
| <input type="checkbox"/> Hospital (Non-profit) _____ # of beds | <input type="checkbox"/> Other (please specify _____) |
| <input type="checkbox"/> Hospital (For-profit) _____ # of beds | <input type="checkbox"/> Standards Developing Organization |
| <input type="checkbox"/> Professional/Trade Association | |

2 Choose Your Dues Level Options!

Select your membership dues level. Representatives receive full membership benefits. Consider adding someone from every department: biomedical and clinical engineering, IT, central service, surgery, anesthesia, administration, nursing, radiology and others. Complete the reverse side of this form. Your membership dues cover a 12-month period. Renewal notices are mailed beginning two months prior to expiration.

- | | |
|--|---------------------------|
| <input type="checkbox"/> \$585 | Three (3) Representatives |
| <input type="checkbox"/> \$760 | Four (4) Representatives |
| <input type="checkbox"/> \$925 | Five (5) Representatives |
| <input type="checkbox"/> \$1,080 | Six (6) Representatives |
| <input type="checkbox"/> \$1,225 | Seven (7) Representatives |
| <input type="checkbox"/> \$1,360 | Eight (8) Representatives |
| <input type="checkbox"/> \$1,465 | Nine (9) Representatives |
| <input type="checkbox"/> \$1,510 | Ten (10) Representatives |
| <hr/> | |
| <input type="checkbox"/> Add _____ Representatives @ \$155 for a total of \$ _____ | |
- Only available for members paying the \$1,510 level dues.

3 Choose Payment Method

- Please charge this credit card:
- Visa MasterCard American Express

Card Number _____

Expiration Date _____


Cardholder Name _____


Cardholder Signature _____


- Check is enclosed made payable to AAMI
Checks must be in U.S. dollars and drawn on a U.S. bank
- Please bill me
Membership services will start when payment is received

While contributions or gifts to AAMI are not tax deductible as charitable contributions for federal income tax purposes, they may be tax deductible under other provisions of the Internal Revenue Code.

4 Submit Application (please complete both sides of this application)

 **Call** 1.800-332-2264, ext. 214
(or 703-525-4890, ext. 214
outside the U.S.) to charge
your membership by phone.

 **Fax** this application with credit
card information to 703-525-1424.

 **Mail** this application along
with your check or credit
card information to:
AAMI, PO Box 890694,
Charlotte, NC 28289-0694.

 Complete the **online** application
at www.aami.org/membership
and submit with credit
card information.

Parent Institution

Name _____

Headquarters Address _____

City _____ State/Province _____ Zip/Post Code _____

Country _____ Main Phone _____

Contact _____ Contact Phone _____ Web site Address _____

Membership Representatives

Please list your full membership representatives below. Your “primary representative” will serve as the main contact person for your membership. Use additional sheets if necessary.

Primary Representative

Provide Office Address/Phone/Fax/E-mail if different from reverse.

1 Name _____

Title _____

Signature _____

Additional Representatives

Provide Office Address/Phone/Fax/E-mail if different from reverse.

2 Name _____

Title _____

3 Name _____

Title _____

4 Name _____

Title _____

5 Name _____

Title _____

6 Name _____

Title _____

7 Name _____

Title _____

8 Name _____

Title _____

9 Name _____

Title _____

10 Name _____

Title _____

Please list any additional employees, all of whom would be eligible for member discounts on AAMI products and services. Use additional sheets if necessary.

