

# Membership Application

## Applicant Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Last* *First* *M.I.*

Address: \_\_\_\_\_

*Street Address* *Apartment/Unit #*

*City* *State* *ZIP Code*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Company /Institution: \_\_\_\_\_

*City*

*State*

*ZIP Code*

Please select the relevant age bracket:  18-24  25-34  35-44  45-54  55-64  65+

I identify my gender as?  Female  Male  Non-Binary  Prefer not to disclose

Which of the following best describes you?  Asian/Pacific Islander  Native American/Alaskan Native  Black/African American  Hispanic/Latino  White/Caucasian  Multiracial/Biracial  A race/ethnicity not listed

Are you interested in volunteering with SVU?  Mentor  Mentee  Committee  Ambassador to Vascular Schools

Would like to continue to receive the print version of JVU, in addition to our current online access?  Yes  No

Certification(s) by professional certifying board or agency:  RVT  RDMS  RDCS  RVS  RPVI  RPhS  RN  CVN  LPN  LVN  RT  RPhS  RTR  CRT  RRT  PA-C  Other: \_\_\_\_\_

Highest Degree Earned:  High School  Some College  Diploma Program  AS  AA  BS  BA  BSN  MS  MA  MSN  Med  MBA  MD  DO  PhD  ScD  JD  Other: \_\_\_\_\_

Work Setting: (check one)  Hospital/Institution  Private Lab/Physician's Office  Equipment Company

Other Organizations of which you are a member:  SDMS  SVS  SVM  ASE  ACP  ASN  ACC  SIR  SVN  ACR  ASRT  AIUM  Other: \_\_\_\_\_

Year you began working in a non-invasive field: \_\_\_\_\_

Specialty of the Physician Medical Director: (check one)  Vascular Surgery  Cardiology  Cardiovascular Surgery  Radiology  Neurology  General Surgery  Other: \_\_\_\_\_

Do you work in an accredited lab?  Yes  No If yes, through which organization is your lab accredited?  IAC  ARC  Other: \_\_\_\_\_

ARDMS #: \_\_\_\_\_

CCI #: \_\_\_\_\_

**Membership Type**

**Note: Approximately 5% of your membership dues will be used for advocacy expenses.**

- Physician Membership (USA/International)**..... **\$255/year**
- Technologists & Sonographers Membership (USA/Canada)**..... **\$155/year**  
Intended for vascular technologists, sonographers, lab directors and all other allied health professionals.
- International Membership (outside USA/Canada)** ..... **\$160/year**  
Intended for vascular technologists, sonographers, lab directors and all other allied health professionals.
- Fellows & Surgical Membership**..... **\$105/year**  
Intended for physicians in training at an accredited hospital. **REQUIRED** to submit proof of status in the form of a letter from department head/program director.
- Student Membership**..... **\$35/year**  
Intended full-time undergraduate or graduate students studying vascular technology or diagnostic medical sonography with a vascular track. **REQUIRED** to submit a letter from the Department Head or Registrar Certifying you are a current student and date of graduation.
- Transitional Membership**..... **\$70/year**  
Available to past SVU Student Members in their first two years after graduation.
- Retired/Disabled Member**..... **\$55/year**  
Retired from active employment or no longer employed and/or permanently disabled. **REQUIRED** Affidavit must be submitted with application.
- Healthcare Industry Partners**..... **\$75/year**  
Non-credentialed Healthcare Industry Partners active in the field, who have an interest in vascular ultrasound and who do not otherwise qualify for another membership category. This may include, but is not limited to healthcare administrators, research scientists, industry professionals. CME is not provided to those in this membership category.

**Additional Donations**

**SVU Foundation**                    \$ \_\_\_\_\_

**Anne Jones Scholarship Fund**    \$ \_\_\_\_\_

**Advocacy Fund**                    \$ \_\_\_\_\_

**Total Amount**  
*(Membership + Donations)*            \$ \_\_\_\_\_

**Payment Method**

**Please make checks payable to "SVU" in US funds drawn on a US bank, net of all bank charges, or use a credit card.**

Visa     MasterCard     American Express

\_\_\_\_\_ *Credit Card Number*

\_\_\_\_\_ *Expiration Date*

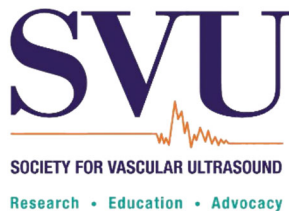
\_\_\_\_\_ *Security Code*

\_\_\_\_\_ *Name on Card*

\_\_\_\_\_ *Billing Address/Zip for Card*

**Please return this form with your payment to:**

Society for Vascular Ultrasound  
P.O. Box 75491  
Baltimore, MD 21275-5491



Society for Vascular Ultrasound