



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: Vascular Surgery Cardiology Cardiovascular Surgery Radiology
 (check one) 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. Rates increase January 1, 2025. Please make sure all checks received after that date are postmarked no later than December 31, 2024 or you will owe the difference before your membership is processed.

- Physician Membership (USA/International)**..... **\$255 ~~\$275~~/year**
- Technologists & Sonographers Membership (USA/Canada)**..... **\$155 ~~\$165~~/year**
Intended for vascular technologists, sonographers, lab directors and all other allied health professionals.
- International Membership (outside USA/Canada)** **\$160 ~~\$165~~/year**
Intended for vascular technologists, sonographers, lab directors and all other allied health professionals.
- Fellows & Surgical Membership**..... **\$105 ~~\$115~~/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 ~~\$75~~/year**
Available to past SVU Student Members in their first two years after graduation.
- Retired/Disabled Member**..... **\$55 ~~\$60~~/year**
Retired from active employment or no longer employed and/or permanently disabled. REQUIRED Affidavit must be submitted with application.
- Healthcare Industry Partners**..... **\$75 ~~\$80~~/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 715491
Philadelphia, PA 19171-5491

