SVU
SOCIETY FOR VASCULAR ULTRASOUND
Research • Education • Advocacy

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 and Payment on page 2.

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 715491
Philadelphia, PA 19171-5491

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