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Society of Hospital Medicine

Membership Application

Join for 1, 2 or 3 years at the current rate. Rates valid through September 30, 2020.

- Physician** \$445⁰⁰/year
- Allied Health Professional (PharmD, RN, etc.)** \$215⁰⁰/year
- Affiliate** \$425⁰⁰/year
- Resident/Fellow** \$95⁰⁰/year
- Practice Administrator** \$215⁰⁰/year
- International Hospitalist** \$115⁰⁰/year
- Nurse Practitioner/Physician Assistant** \$215⁰⁰/year
- Student** FREE

Referred by (if applicable)		
First Name	Last Name	Credentials (i.e. MD, NP)
Title	Specialty	
Hospital/Institution (if applicable)		
Residency Program Name *		
Medical School Name*	Graduation/Anticipated Graduation Date*	
First Year Working in a Hospital Medicine Setting or Anticipated Date.		Date of Birth
Mailing Address <input type="checkbox"/> Work <input type="checkbox"/> Home		
City	State/Province	Zip
Phone	Is this a mobile number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email (required)

Please check below to indicate preferred contact method.

Checking below indicates consent to receive communications including, but not limited to, information sent by SHM/SHM Chapters.

<input type="checkbox"/> Email	Signature	Date
<input type="checkbox"/> Postal Mail		

Payment Information

- Check (payable to SHM) enclosed **OR**   

Cardholder's Name		
Credit Card Number	Expiration Date	
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MAIL TO

Society of Hospital Medicine, ATTN: Membership Department, 1500 Spring Garden Street, Suite 501, Philadelphia, PA 19130

 800-843-3360

 267-702-2690

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Periodically, SHM will make its mailing list available to carefully screened third parties who may share communications with you. The revenue that SHM receives from this program allows us to keep your membership dues at the lowest rate possible.

Please check if you elect NOT to receive these types of communications.

*Required for Resident/Fellow and Student Membership