Society of Hospital Medicine Membership Application

STEP 1 - MEMBERSHIP TYPE *(Expires one year from join date)*

❑ Physician: $385
❑ Allied Health Professional (PharmD, RN, etc.): $215
❑ NP/PA: $215
❑ Affiliate (includes Practice Administrators): $375
❑ International $115
❑ Resident/Fellow $100
❑ Student (includes MD, DO, NP/PA, etc.) FREE

STEP 2 - APPLICANT INFORMATION

Name:
Title:
Address:
City:
State/Province: Zip:
Country:
Phone: Fax:
Email:
How did you hear about SHM?
If by a colleague, please indicate name:

Communication Preferences
Please indicate preferred communication methods. By checking below, you consent to receive communications including, but not limited to, information sent by SHM and SHM's Chapters.

❑ Email ❑ Postal Mail ❑ Fax

STEP 3 - MEDICAL EDUCATION *(If applicable)*

Medical School:
Graduated/Anticipated Graduation Date:
State/Country:
Degree Earned:
Specialty/Subspecialty:
Certifications/Year Certified:
Licensure (State):
NPI #:

STEP 4 - PRACTICE INFORMATION

Hospital Medicine Group (HMG) Name:
Primary Hospital:
State/Province:
HMG Leader:

Practice Type: ❑ Adult ❑ Children ❑ Both
Program Start Date:
Number of Members in Group:

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STEP 5 - MEMBERSHIP STATISTICAL DATA *(Completion is encouraged, but optional.)*

Gender: ❑ Male ❑ Female

Date of Birth:

Year You Became a Hospitalist:

(Please select one)

❑ African, African-American, or Black
❑ Asian, Asian-American
❑ Arabic, Middle-Eastern
❑ Caucasian/White (not of Hispanic Origin)
❑ Hispanic, Latino, or Spanish
❑ Asian Indian
❑ Native American or First Nations
❑ Pacific Islander, Native Hawaiian
❑ Other, please specify:

❑ Prefer not to Answer

Other Medical Societies That You Belong to

❑ AAFP ❑ AANP ❑ AAP ❑ AAPA ❑ ACOI ❑ ACP ❑ ACPE ❑ AMA ❑ AOA ❑ APA ❑ SGIM

Other:

Employer Model? (Please select one.)

❑ Hospital or hospital-managed corporation
❑ Local hospitalist-only group
❑ Multi-specialty or primary care medical group
❑ Multi-state group or hospitalist management company
❑ University or medical school
❑ Other, please specify:

Periodically, SHM will make its mailing list available to carefully screened third parties that may share communications with you. The revenue received enables SHM to keep your membership dues at the lowest rate possible.

❑ Please check if you elect not to receive these communications.

STEP 6 - METHOD OF PAYMENT

Total Due $

Credit Card: ❑ MasterCard ❑ Visa ❑ American Express

Card #:

Name on Card:

Exp. Date: CVV:

Date :

Signature:

❑ Check (payable to SHM) is enclosed.

Join Today.

T: 800-843-3360
www.joinshm.org
F: 267-702-2690

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Philadelphia, PA 19182-2898

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