SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

STUDENT MEMBERSHIP APPLICATION

Name Mr./Ms./Dr. _____ (First) _____ (MI) _____ (Last) Credentials _____

Organization _____ Department _____

Mailing Address ☐ Home ☐ Work _____

City _____ State/Province _____ Zip+4/Postal Code _____

Country _____ (If not US) Daytime Phone ( ) _____ ext. _____

Email _____

Communication preferences may be customized through your SDMS member profile.

Please provide us with the following information. It will be used strictly for verification and CME tracking purposes only.

Date of Birth: ____/____/____ *(MM/DD/YYYY)*

Gender: ☐ Female ☐ Male

Highest Diploma/Degree:

☐ High School/GED ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate

Degree Area: _____

Credentials/Licenses:

☐ RDCS ☐ RDMS ☐ RMSK ☐ RMSKS ☐ RPVI ☐ RVT

ARDMS Registry # _____

CME Period Expiration *(MM/DD/YYYY)* ____/____/____

☐ ACS ☐ RCCS ☐ RCIS ☐ RCS ☐ RPhS ☐ RVS

CCI Registry # _____

CME Period Expiration *(MM/DD/YYYY)* ____/____/____

☐ RT(BS) [Breast] ☐ RT(S) ☐ RT(VS) [Vascular]

ARRT Registry # _____

CME Period Expiration *(MM/DD/YYYY)* ____/____/____

☐ CRCS ☐ CRGS ☐ CRVS

Sonography Canada Registry # _____

CME Period Expiration *(MM/DD/YYYY)* ____/____/____

Specialties:

Practicing	Certified	Practicing	Certified	Practicing	Certified	Practicing	Certified
☐	☐ Abdomen [AB]	☐	☐ Cardiac (Fetal) [FE]	☐	☐ OB/GYN [OB]	☐	☐ Veterinary
☐	☐ Breast [BR]	☐	☐ Cardiac (Ped) [PE]	☐	☐ Pediatric Sonography [PS]	☐	☐ None
☐	☐ Cardiac (Adult) [AE]	☐	☐ Neurosonology [NE]	☐	☐ Vascular [VT]		

Membership Dues*: $45 USD $45

**Student membership requires that your program faculty verify your student status and anticipated graduation date by completing the student status verification section attached to this application.*

Donation to the SDMS Foundation: ☐ $10 ☐ $15 ☐ $25 ☐ $50 ☐ $75 ☐ $100 ☐ Other: $_____ _____

The Society of Diagnostic Medical Sonography (SDMS) Foundation is recognized by the Internal Revenue Service (IRS) as a tax exempt charitable organization described in section 501(c)(3) of the Internal Revenue Code. Your donation will be deductible to the extent permitted by law.

TOTAL: _____

Indicate Payment (*PLEASE PRINT*) *Expedite your membership application. Pay online now at* ***sdms.org/join***

☐ Credit Card

☐ Check/ Money Order

Credit Card Number: _____ CID: _____ *(3 or 4 digit code)* Expiration Date: _____

Cardholder's Name (as it appears on card) _____ Signature _____

Cardholder's Billing Address (as it appears on statement – Please include address, city, state/province, and zip/postal code) _____

NOTE: This form is valid through 12/31/18

Payment by check authorizes the SDMS to process funds by electronic funds transfer (ACH). Membership dues to the SDMS are not tax deductible as a charitable contribution. For information on partially deducting membership dues as a business expense, go to sdms.org/taxes. SDMS takes the privacy of your personal information very seriously and will use your information only in accordance with the terms of the SDMS Privacy Policy, available at: sdms.org/privacy

Please return completed two-page application with appropriate dues payment to:

SDMS Membership Department • PO Box 200971, Dallas, TX 75320-0971 • 800.229.9506 • +1 214.473.8057 • +1 214.473.8563 Fax

Please type or print.

Student Status Verification

A SDMS Student member is defined as *an individual who is currently enrolled in a Diagnostic Medical Sonography or related program and will be considered a Student Member until completion of the educational program.*

To comply with the SDMS Student Membership requirements, student status must be verified by the applicant's current program faculty. The student dues payment must accompany this fully completed two-page membership application.

Student applications may be submitted by mail, fax, or email or online at sdms.org/join. Applications must be received before the applicant's graduation date to be considered for SDMS Student Membership. If the applicant does not meet the SDMS Student Membership requirements, the dues payment will be refunded.

Program Faculty Affirmation

I hereby confirm that the applicant for SDMS Student membership is currently accepted or enrolled in a sonography-related educational program and the information provided in this section of the membership application is accurate. I understand that providing false or misleading information may result in denial of the application and other actions deemed appropriate by the SDMS.

_____ _____ _____

Program Faculty Signature Date SDMS #

Printed Name: _____

Program Role: ☐ Clinical Coordinator ☐ Faculty/ Instructor ☐ Program Director ☐ Other

Program Faculty Email _____ Daytime Phone_____

Student Name: _____

Student Anticipated Graduation Date: _____
(mm/dd/yyyy)

Program Information

School Name: _____

Program Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____ Country: _____

Website: _____

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