



SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

STANDARD MEMBERSHIP APPLICATION

Name _____ First _____ MI _____ Last _____ Credentials _____

Organization _____

Mailing Address Home Work _____

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

Country _____ Phone Mobile (_____) Work _____
(If not US)

Email _____ Communication preferences may be customized through your SDMS member profile.

Please provide us with the following information. It will be used for verification and CME tracking purposes only.
Date of Birth: ____ / ____ / ____ (MM/DD/YYYY)
Gender: Female Male Prefer Not to Specify

Highest Diploma/Degree:
 High School/GED Master's Degree
 Associate's Degree Doctorate
 Bachelor's Degree

Job Category: Clinical/ Management Education Industry Representative **Date Began in Sonography:** ____ / ____ / ____ (MM/DD/YYYY)

Credentials/Licenses:

<input type="checkbox"/> RDCS	<input type="checkbox"/> RMSKS	<input type="checkbox"/> ACS	<input type="checkbox"/> RCS	<input type="checkbox"/> RT(BS) [Breast]	<input type="checkbox"/> CRCS
<input type="checkbox"/> RDMS	<input type="checkbox"/> RPVI	<input type="checkbox"/> RCCS	<input type="checkbox"/> RPhS	<input type="checkbox"/> RT(S)	<input type="checkbox"/> CRGS
<input type="checkbox"/> RMSK	<input type="checkbox"/> RVT	<input type="checkbox"/> RCIS	<input type="checkbox"/> RVS	<input type="checkbox"/> RT(VS) [Vascular]	<input type="checkbox"/> CRVS

ARDMS Registry # _____	CCI Registry # _____	ARRT Registry # _____	Sonography Canada Registry # _____
____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
CME Period Expiration (MM/DD/YYYY) _____	CME Period Expiration (MM/DD/YYYY) _____	CME Period Expiration (MM/DD/YYYY) _____	CME Period Expiration (MM/DD/YYYY) _____

Specialties:

Practicing <input type="checkbox"/>	Certified <input type="checkbox"/>	Abdomen [AB]	Practicing <input type="checkbox"/>	Certified <input type="checkbox"/>	Cardiac (Fetal) [FE]	Practicing <input type="checkbox"/>	Certified <input type="checkbox"/>	Neurosonology [NE]	Practicing <input type="checkbox"/>	Certified <input type="checkbox"/>	Vascular [VT]
<input type="checkbox"/>	<input type="checkbox"/>	Breast [BR]	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac (Ped) [PE]	<input type="checkbox"/>	<input type="checkbox"/>	OB/GYN [OB]	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Veterinary
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac (Adult) [AE]	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal [MSK]	<input type="checkbox"/>	<input type="checkbox"/>	Pediatric Sonography [PS]	<input type="checkbox"/>	<input type="checkbox"/>	None

Membership Dues*: 1 - Year \$160 USD 2 - Year \$290 USD 3 - Year \$420 USD \$ _____

*Membership in the Student category requires additional documentation and a specific application. Please go online at sdms.org for more information about Student membership.

Donation to the SDMS Foundation: \$10 \$25 \$50 \$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 Credit Card Number: _____ CID: _____ Expiration Date: _____
(3 or 4 digit code)

Check/ Money Order _____
Cardholder's Name (as it appears on card) _____ Signature _____

NOTE:
This form is valid through 12/31/22

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

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 application with appropriate dues payment to:

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

Questions? 800.229.9506 • +1 214.473.8057 • membership@sdms.org