SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

ORGANIZATIONAL MEMBERSHIP APPLICATION

Organization Name ______________________________

Address ______________________________

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

Country ____________ (If not US) Website ____________

Primary Contact Mr./Ms./Dr ____________ First MI Last

Email (required) ______________________________

Daytime Phone ( ) ____________ ext. ________ SDMS # ____________

SDMS ORGANIZATIONAL MEMBERSHIPS	OPTIONS AVAILABLE*				
Benefits	Tier 1	Tier 2	Tier 3 (Best Value!)	Tier 4	Tier 5
Annual Membership Dues (USD)**	$250	$750	$1,400	$3,250	$6,000
Includes: SDMS Standard Memberships	0	5	10	25	50
Includes: SDMS Clinical Instructorship CME Credit (CAAHEP Accredited Educational Programs Only)	✓	✓	✓	✓	✓
Discounts: SDMS CME Activity Application Fees	✓	✓	✓	✓	✓
Discounts: SDMS Store	✓	✓	✓	✓	✓
Discounts: SDMS Annual Conference Registrations	✓	✓	✓	✓	✓
Includes: Organizational JDMS Subscription (print only)		✓	✓	✓	✓
Discounts: SDMS Organizational Professional Liability Insurance***			✓	✓	✓
Discounts: SDMS Job Board Postings				✓	✓
Includes: SDMS Medal Level Recognition (guaranteed minimum of Bronze level recognition)					✓

* Checkmark (✓) indicates the benefit is included in the Organizational Membership Tier.
** Discounted pricing is available for CAAHEP accredited educational programs.
*** Coverage is not guaranteed. Must complete application and qualify through SDMS Insurance Services.

Membership Tier/ Dues: ☐ Tier 1/ $250 ☐ Tier 2/ $750 ☐ Tier 3/ $1,400 ☐ Tier 4/ $3,250 ☐ Tier 5/ $6,000 $ ________

Donation to the SDMS Foundation: ☐ $50 ☐ $100 ☐ $250 ☐ $500 ☐ $1000 ☐ 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*)

☐ Credit Card Credit Card Number: ____________ CID: ______ (*3 or 4 digit code*) Expiration Date: ______

☐ Check/ Money Order

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 12/31/21

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 • 2745 Dallas Pkwy Ste 350, Plano, TX 75093-8730 • 800.229.9506 • +1 214.473.8057 • +1 214.473.8563 Fax

SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

ORGANIZATIONAL BENEFICIARY FORM

This form must be used to add individual beneficiaries to your SDMS organizational membership. Please provide the requested information in the table below for each individual receiving SDMS membership benefits under the organizational membership. A membership application must be provided for each beneficiary who is not a current SDMS customer.

Beneficiary List (attach additional pages with this section's information if needed for more beneficiaries)

Beneficiary Name (First & Last)	Email Address	Date of Birth	ARDMS # (if applicable)	SDMS # (if applicable)
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________
		___/___/______	______________	______________

Primary Contact Affirmation

As the primary contact for this SDMS organizational membership, I hereby attest that I have the authority to give consent for the contacts listed above to receive SDMS communications (i.e., email and physical mail). I understand that each contact listed above may subsequently make changes to their personal communications preferences in the "My Profile" area of the SDMS website (sdms.org/membership/manage-membership/my-profile). I understand that beneficiary information must be provided within 2 months of initial membership and may only be changed during future open enrollment periods, beginning 90 days prior to the organization's membership expiration date through the expiration date.

Signature: ____ Date: ______________

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