

Organization Name

## SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

Address			
City	State/Province_	Zip+4/Postal Code	
Country (If not US)	Website	·	
Primary Contact	First	MI	_ast
Email (required)			
Daytime Phone ( )	ext	SDMS #	

	SDMS Organizational Annual Dues	SDMS Standard Memberships Included
Tier 1	\$275	0
Tier 2	\$825	5
Tier 3	\$1,600	10
Tier 4	\$4,000	25
Tier 5	\$7,500	50
Tier 6	\$14,500	100

Membership Tier/ Dues:	_Tier 1/\$27	5 🗌 Tier	2/\$825	□ Tier 3/\$1	,600 🗌 T	ier 4/\$4,000	□Tier 5/ \$7,	500 □Tier 6/\$14,500
								\$
Add additional Standard I	Vembershi	ps to any	Membe	rship Tier fo	or \$165 e	<b>ach:</b> Quantity	/ x \$165:	\$
Donation to the SDMS Fo	undation:	□\$50	□\$100	□ \$250	□ \$500	□ \$1000	□Other	\$
The Society of Diagnostic Medical Service (IRS) as a tax exempt chari Code. Your donation will be deduc	table organizat	tion described	d in section	<i>,</i>				TOTAL: \$
Indicate Payment (PLEASE	E PRINT)							
Credit Card	Credit Card N	Number:				(	CID: E	Expiration Date:
Check/ Money Order							(5 67 / algr code)	
<b>NOTE:</b> This form is valid	Cardholder's	Name (as it	appears on	n card)	S	ignature		
through 12/31/2024	Cardholder's E	Billing Addres	s (as it appe	ears on statemer	nt – Please ind	clude address, cit	y, state/province, a	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 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



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)
		/		
		/		
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## **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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