



# SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

## STUDENT MEMBERSHIP APPLICATION

Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Credentials \_\_\_\_\_

Organization \_\_\_\_\_

Mailing Address ☐ Home ☐ Work \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip+4/Postal Code \_\_\_\_\_

Country \_\_\_\_\_ (If not US) Phone ☐ Mobile ( ) ☐ Work \_\_\_\_\_

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

### Credentials/Licenses:

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

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

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

- ☐ CRCS  
☐ CRGS  
☐ CRVS

ARDMS Registry #  
\_\_\_\_/\_\_\_\_/\_\_\_\_

CME Period Expiration (MM/DD/YYYY)

CCI Registry #  
\_\_\_\_/\_\_\_\_/\_\_\_\_

CME Period Expiration (MM/DD/YYYY)

ARRT Registry #  
\_\_\_\_/\_\_\_\_/\_\_\_\_

CME Period Expiration (MM/DD/YYYY)

Sonography Canada Registry #  
\_\_\_\_/\_\_\_\_/\_\_\_\_

CME Period Expiration (MM/DD/YYYY)

### Specialties:

Practicing Certified

- ☐ ☐ Abdomen [AB]  
☐ ☐ Breast [BR]  
☐ ☐ Cardiac (Adult) [AE]

Practicing Certified

- ☐ ☐ Cardiac (Fetal) [FE]  
☐ ☐ Cardiac (Ped) [PE]  
☐ ☐ Musculoskeletal [MSK]

Practicing Certified

- ☐ ☐ Neurosonology [NE]  
☐ ☐ OB/GYN [OB]  
☐ ☐ Pediatric Sonography [PS]

Practicing Certified

- ☐ ☐ Vascular [VT]  
☐ ☒ Veterinary  
☐ None

**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:** ☐ \$15 ☐ \$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](https://sdms.org/join)

☐ Credit Card Credit Card Number: \_\_\_\_\_ CID: \_\_\_\_\_ (3 or 4 digit code) Expiration Date: \_\_\_\_\_

☐ Check/ Money Order

#### NOTE:

This form is valid  
through 12/31/2026

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) \_\_\_\_\_

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](https://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](https://sdms.org/privacy)

**Please return completed application with appropriate dues payment to:**

SDMS Membership Department • PO Box 200971, Dallas, TX 75320-0971

**Questions?** 800.229.9506 • +1 214.473.8057 • [membership@sdms.org](mailto:membership@sdms.org)



# SDMS STUDENT STATUS VERIFICATION FORM

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

To comply with the SDMS Student Membership or SDMS Foundation program eligibility requirements, student status must be verified by the applicant's current program faculty by completing this form.

Student membership applications may be submitted by mail, fax, or email or online at [sdms.org/join](http://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 is currently accepted or enrolled in a sonography or other healthcare-related educational program and the information provided in this section 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 or SDMS Foundation.*

Program Faculty Signature \_\_\_\_\_ Date \_\_\_\_\_ SDMS # \_\_\_\_\_

Printed Name \_\_\_\_\_

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

Program Faculty Email \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_

Student Name \_\_\_\_\_

Student Anticipated Graduation Date \_\_\_\_\_ SDMS # \_\_\_\_\_  
(mm/dd/yyyy) if applicable

## PROGRAM INFORMATION

School Name \_\_\_\_\_

Program Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip+4/Postal Code \_\_\_\_\_

Website \_\_\_\_\_