

PENNSYLVANIA STATE PERFUSION SOCIETY MEMBERSHIP APPLICATION

Personal Information

Name:	Employer: (Include Hospital and/or Employer)
Address:	Work Address:
Email:	How may PSPS contact you? (Check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> E-Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Home Fax <input type="checkbox"/> Work Fax <input type="checkbox"/> Pager
Home Phone:	
Home Fax:	
Work Fax:	
Cell Phone:	
Pager:	

Membership Fees

<input type="checkbox"/> New Application <input type="checkbox"/> Renewal Application	<input type="checkbox"/> Active (\$55) <input type="checkbox"/> Sustaining (\$40) <input type="checkbox"/> Student (\$15)
Calendar Year of Application _____ <small>Membership runs January through December</small>	

Professional Status:

Credentials	Job Title	Type of Employment
<input type="checkbox"/> CCP <input type="checkbox"/> CCT <input type="checkbox"/> RN <input type="checkbox"/> RT <input type="checkbox"/> Other	<input type="checkbox"/> Chief Perfusionist <input type="checkbox"/> Staff Perfusionist <input type="checkbox"/> Perfusion Educator <input type="checkbox"/> Owner <input type="checkbox"/> Perfusion Assistant <input type="checkbox"/> Autotransfusionist <input type="checkbox"/> Manufacturer's Rep <input type="checkbox"/> Other	<input type="checkbox"/> Hospital Employee <input type="checkbox"/> Perfusion Services Contract Co. <input type="checkbox"/> Surgical Group <input type="checkbox"/> Self Employed (Independent) <input type="checkbox"/> Manufacturer/Distributor <input type="checkbox"/> Perfusion School Faculty

Willingness to Serve

Committees <input type="checkbox"/> Finance & Fundraising <input type="checkbox"/> Government Relations <input type="checkbox"/> Membership <input type="checkbox"/> Continuing Education <input type="checkbox"/> Communications	<input type="checkbox"/> I would be willing to serve as a regional representative: Indicate Region <input type="checkbox"/> NE <input type="checkbox"/> SE <input type="checkbox"/> Central <input type="checkbox"/> NW <input type="checkbox"/> SW <input type="checkbox"/> I would be willing to run for office and serve on the board. <input type="checkbox"/> I would be willing to host and tour a state legislator at my hospital.
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Please Mail the form and Membership Fee to:

Tammy Strippel

PO Box 8257, Lancaster, PA 17604-8257

Phone: 717-544-5224