SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

STUDENT MEMBERSHIP APPLICATION

Name Mr./Ms./Dr. _____ (First) ____ (MI) _____ (Last) Credentials _____

Address 1 _____

Address 2 _____

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

Country _____ (If not US) Daytime Phone ( ) _____ ext. _____

Email _____

Subscription preferences may be customized through your SDMS member profile.

Please provide us with the following information. It will be used strictly for verification and CME tracking purposes only.

Date of Birth: ____/____/____ *(MM/DD/YYYY)*

Social Security #: XXX-XX-_____ *(last 4 digits only)*

Gender: ☐ Female ☐ Male

Specialty Areas Currently Studying:

☐ Abdomen
☐ Breast
☐ Cardiac (Adult)
☐ Cardiac (Fetal)
☐ Cardiac (Ped)
☐ Musculoskeletal
☐ Neurosonology
☐ OB/GYN
☐ Pediatric Sonography
☐ Vascular
☐ Veterinary

Credentials/Licenses:

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

_____ ARDMS Registry #

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

_____ CCI Registry #

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

_____ ARRT Registry #

☐ CRCS
☐ CRGS
☐ CRVS

_____ Sonography Canada Registry #

☐ MD/DO
☐ RN
☐ Other

_____

Specialty Certifications:

☐ Abdomen [AB]
☐ Breast [BR]
☐ Cardiac (Adult) [AE]
☐ Cardiac (Fetal) [FE]
☐ Cardiac (Ped) [PE]
☐ Neurosonology [NE]
☐ OB/GYN [OB]
☐ Pediatric Sonography [PS]
☐ Vascular [VT]
☐ None

Highest Diploma/Degree:

☐ High School/GED
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctorate

SDMS Student Membership Dues*: $45 USD _____ $45 _____

Donation to the SDMS Foundation: ☐ $10 ☐ $15 ☐ $25 ☐ $50 ☐ $75 ☐ $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*)

☐ Check/Money Order
Payment by check authorizes the SDMS to process funds by electronic fund transfer (ACH).

☐ American Express
☐ Discover
☐ Mastercard
☐ VISA

Credit Card Number: _____ CID: _____ *(3 or 4 digit code)* Expiration Date: _____

_____ 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)

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.

NOTE: This form is valid through 12/31/17

Membership dues and SDMS Foundation donations are non-transferrable and non-refundable except in the event of an overpayment. Membership dues to the SDMS are not deductible as a charitable contribution for U.S. Federal tax purposes, but may be partially deductible as a business expense. The SDMS estimates 4% of your dues are not deductible because of the SDMS' lobbying activities on behalf of its members.

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. The Privacy Policy applies to all services that are hosted on the SDMS web site, information gathered in writing, or through any other electronic methods. You may view the SDMS Privacy Policy at: sdms.org/privacy

Please type or print.

Student Status Verification

A SDMS Student member is defined as an individual who is currently enrolled in a diagnostic medical sonography program and must be considered a Student Member until completion of the educational program. A Student Member shall have all the benefits granted by the Society, but shall not have the right to hold an elective office or be elevated to Fellow.

To comply with the SDMS Student Membership requirements, student status must be verified by the applicant's current program faculty. The student dues payment must accompany this fully completed two-page membership application.

Student applications must be received on or 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 for SDMS Student membership is currently accepted or enrolled in a sonography-related educational program and the information provided in this section of the membership application 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.

_____ _____ _____

Program Faculty Signature Date SDMS #

Printed Name: _____

Student Name: _____

Student Anticipated Graduation Date: _____
(mm/dd/yyyy)

Program Information

School Name: _____

Program Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____ Country: _____

Daytime Phone: _____ Email Address: _____

Please return completed two-page application with appropriate dues payment to:

SDMS Membership Department • PO Box 200971, Dallas, TX 75320-0971 • 800.229.9506 • +1 214.473.8057 • 214.473.8563 Fax