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
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctorate

Credentials/Licenses:

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

ARDMS Registry # _____
____/____/____ CME Period Expiration *(MM/DD/YYYY)*

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

CCI Registry # _____
____/____/____ CME Period Expiration *(MM/DD/YYYY)*

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

ARRT Registry # _____
____/____/____ CME Period Expiration *(MM/DD/YYYY)*

☐ CRCS
☐ CRGS
☐ CRVS

Sonography Canada Registry # _____
____/____/____ CME Period Expiration *(MM/DD/YYYY)*

Specialties:

Practicing	Certified	
☐	☐	Abdomen [AB]
☐	☐	Breast [BR]
☐	☐	Cardiac (Adult) [AE]
☐	☐	Cardiac (Fetal) [FE]
☐	☐	Cardiac (Ped) [PE]
☐	☐	Musculoskeletal [MSK]
☐	☐	Neurosonology [NE]
☐	☐	OB/GYN [OB]
☐	☐	Pediatric Sonography [PS]
☐	☐	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***

☐ Credit Card
☐ Check/ Money Order

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) _____

NOTE: This form is valid through 12/31/2025

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 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

SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY FOUNDATION

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. 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 _____

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