SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

ORGANIZATIONAL MEMBERSHIP APPLICATION

Organization Name _____

Address _____

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

Country _____ (If not US) Website _____

Primary Contact _____ (First) (MI) (Last)

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/$275 ☐ Tier 2/$825 ☐ Tier 3/$1,600 ☐ Tier 4/$4,000 ☐ Tier 5/ $7,500 ☐ Tier 6/$14,500

☐ ☐ ☐ ☐ ☐ ☐ $ _____

Add additional Standard Memberships to any Membership Tier for $165 each: Quantity _____ x $165: $ _____

Donation to the SDMS Foundation: ☐ $50 ☐ $100 ☐ $250 ☐ $500 ☐ $1000 ☐ 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*)

☐ 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 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

SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHY

ORGANIZATIONAL BENEFICIARY FORM

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)
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____
		___/___/_____	_____	_____

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: _____

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

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