



MEMBERSHIP APPLICATION

Please indicate your professional capacity (choose one):

MD DO PhD CRNA RN CCRN Paramedic EMT

NAME: _____

DEGREES: _____

STREET ADDRESS: _____

CITY: _____

STATE: _____

POSTAL CODE: _____

COUNTRY: _____

TELEPHONE: _____

FAX: _____

EMAIL ADDRESS: _____

MEMBERSHIP LEVEL:

- Corporate (\$1000 US annually)
 Full Member (\$200 US annually)
 Member in Training (\$40 US annually ; letters verifying training status are required)

PAYMENT OPTIONS:

- US Check (US residents only; check payable to "ITACCS")
 International Draft – Must be made payable to "ITACCS" through a US bank in US dollars
 Bank Transfers – Must be written in US dollars; verification of transfer from sending Financial Institution must accompany this form. Please have funds transferred to "ITACCS" account number 169-8133-3 with First national bank of Maryland routing number 052000113
 Mastercard and Visa are accepted methods of payment, the charge will appear on your statement as "Anesthesia Seminars".

CREDIT CARD INFORMATION:

Type of Card: ___ MC ___ VISA

Name on Card: _____

Card Number: _____

Card Expiration Date: _____

Signature: _____

PLEASE SEND MORE INFORMATION ON (check all that apply):

- ___ ATACCS Annual Meeting
- ___ ATACCS/ITACCS Sponsor/Exhibitor/Advertiser
- ___ Official ITACCS Scientific Abstract Instructions
- ___ ITACCS Research Award Prospectus
- ___ ITACCS Committees
- ___ ITACCS Developing Nations Program
- ___ Trauma Training Programs
- ___ ITACCS Publications (TraumaCare Journal, Books, Momographs)
- ___ ITACCS Clinical Consultant Service
- ___ ITACCS Audiotapes/Videotapes
- ___ OTHER (please specify) _____

APPLICATION INSTRUCTIONS

Print this form, fill it out completely, mail or FAX along with your payment to:

ITACCS World Headquarters
PO BOX 4826
Baltimore, MD 21211-9889
USA

FAX: 410-235-8084