

CONTACT INFORMATION (Please type or print)

*Name (Jonathan A. Smith, MD): _____

*Institution: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

*Email: _____

Home Address: _____

City: _____ State: _____ Zip _____

Secondary Email: _____

Preferred Contact Method: Mail Email

Gender: Male Female

*Are you a Current Member: Yes No

Date of Birth: _____

*Required Field

MEMBERSHIP SELECTION

- | | |
|---|----------|
| <input type="checkbox"/> Faculty | \$645.00 |
| <input type="checkbox"/> Young Physician Year 2 | \$455.00 |
| <input type="checkbox"/> Associate | \$295.00 |
| <input type="checkbox"/> Young Physician Year 1 | \$265.00 |
| <input type="checkbox"/> Military | \$260.00 |
| <input type="checkbox"/> Resident | \$180.00 |
| <input type="checkbox"/> Fellow | \$180.00 |
| <input type="checkbox"/> Medical Student | \$ 25.00 |
| <input type="checkbox"/> Emeritus | \$100.00 |

ACADEMY SELECTION

	Resident or Medical Student	Associate, Fellow, Military, YP1, YP2, Emeritus	Faculty
ADIEM	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100
AEUS	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100
AGEM	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100
AWAEM	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100
CDEM	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100
GEMA	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100
Simulation	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100

INTEREST GROUPS Please select your free interest groups below.

- | | | |
|--|---|---|
| <input type="checkbox"/> Academic Informatics | <input type="checkbox"/> Airway | <input type="checkbox"/> APP Medical Directors |
| <input type="checkbox"/> Climate Change and Health | <input type="checkbox"/> CPR/Ischemia/Reperfusion | <input type="checkbox"/> Critical Care Medicine |
| <input type="checkbox"/> Disaster Medicine | <input type="checkbox"/> Educational Research | <input type="checkbox"/> Evidence Based Healthcare & Implementation |
| <input type="checkbox"/> Emergency Medical Services | <input type="checkbox"/> EMTIDE Interest Group | <input type="checkbox"/> Observation Medicine |
| <input type="checkbox"/> Medical Quality Management | <input type="checkbox"/> Neurologic EM | <input type="checkbox"/> Palliative Medicine |
| <input type="checkbox"/> Oncologic Emergencies | <input type="checkbox"/> Operations | <input type="checkbox"/> Sex and Gender in EM |
| <input type="checkbox"/> Patient Safety | <input type="checkbox"/> Pediatric EM | <input type="checkbox"/> Telehealth |
| <input type="checkbox"/> Social EM and Population Health | <input type="checkbox"/> Sports Medicine | <input type="checkbox"/> Uniformed Services |
| <input type="checkbox"/> Toxicology | <input type="checkbox"/> Trauma | |
| <input type="checkbox"/> Wilderness Medicine | | |

I would like to give an additional gift to the SAEM Foundation

\$1,000 \$500 \$250 \$100 Other \$ _____

METHOD OF PAYMENT

Visa MasterCard AmEx Discover Checks should be made payable to SAEM

Name on Card: _____ Total: _____

Card Number: _____ Expiration: _____ CVV#: _____

Signature: _____