



Please provide the following information, allowing NAMS to better serve the needs of its members.

**Profession (choose only one):**

- Administrator
- Educator
- Exercise Specialist
- Healthcare Industry
- Mental Health Professional
- Nurse
- Nurse Practitioner
- Nurse Midwife
- Nutritionist
- Pharmacist
- Physician
- Physician Assistant
- Publishing/Writing
- Researcher
- Other: \_\_\_\_\_

**Primarily involved in (choose only one):**

- Clinical Practice
- Research
- Other: \_\_\_\_\_

**Specialty (choose only one):**

- Menopause
- Obstetrics/Gynecology
- Gynecology
- Reproductive Endocrinology
- Endocrinology
- Geriatrics
- Family Practice
- Internal Medicine
- Cardiology
- Mental Health
- Urology
- Public Health
- Radiology
- Rheumatology
- Women's Health
- Bone Health
- Oncology
- Fitness
- Nutrition
- Other: \_\_\_\_\_

**Do you wish to receive the following e-mail alerts from NAMS?**

- General News, including *Flashes*<sup>®</sup> monthly e-newsletter (Society activities, surveys, educational offerings)
- First to Know*<sup>®</sup> e-newsletter (scientific news with expert commentary)
- Menopause e-Consult*<sup>®</sup> e-newsletter (clinical questions and cases)
- Menopause Flashes*<sup>®</sup> e-newsletter (consumer e-newsletter)

**NAMS offers consumers a referral list.**

**Please indicate if you wish to be listed in the:**

- Menopause Clinician referral list.
- Use the address and telephone number on the reverse side of this application.
- Use a different address and telephone number (enclosed).

**NAMS occasionally rents the names and postal addresses of its members to third parties for educational mailings, provided the contents are approved by the NAMS Board of Trustees. Do you wish to receive these mailings?**

- Yes
- No

**Mail to:**

The North American Menopause Society  
Post Office Box 94527  
Cleveland, OH 44101-4527  
USA

**Telephone** 440.442.7550

**Fax** 440.442.2660

**E-Mail** info@menopause.org

**Web Site** www.menopause.org

**For Associate Member Applicants Only**

The eligibility requirements for an Associate member are found under "Becoming a Member." If you qualify, please verify your status by having an authorized representative (such as professor or director of residency or fellowship program) complete the section below.

I hereby certify that this applicant is qualified for Associate Member status by being a student, resident, or fellow in a formal training program, finishing the program on \_\_\_\_\_

Date

Signature

Date