Membership Application

All health professionals with an interest in the many issues affecting women as they approach menopause and beyond are invited to apply for membership in The North American Menopause Society (NAMS) by completing both sides of this form. This information will be used only to contact you regarding your membership.

Last Name  First Name  Middle Initial

Credentials (eg, MD, PhD, RN, NP)

Address

Street/P.O. Box  City

State/Province  ZIP/Postal Code  Country

Telephone  Fax

Email Address

As a member, I agree to support the Mission and to further the efforts of the Society. I have completed the reverse side of this form, and have enclosed payment of annual dues for the member category indicated below.

Signature of Applicant  Date

<table>
<thead>
<tr>
<th>Member Category</th>
<th>Annual Dues (Jan.-Dec.)</th>
<th>Half-Year Dues (July-Dec.)</th>
<th>Amount Enclosed</th>
<th>Method of Payment</th>
<th>Cardholder’s City</th>
<th>State</th>
<th>ZIP/Postal Code</th>
<th>Card Number</th>
<th>Expiration Date</th>
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</thead>
<tbody>
<tr>
<td>Active Member</td>
<td>$275.00</td>
<td>$200.00</td>
<td>$_______</td>
<td>Check (in U.S. funds) enclosed, made payable to:</td>
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<td>The North American Menopause Society</td>
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<td>Associate Member</td>
<td>$160.00</td>
<td>$155.00</td>
<td>$_______</td>
<td>VISA</td>
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<td>(student, resident, fellow)</td>
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<td>MasterCard</td>
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<td>American Express</td>
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<td>Discover</td>
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<td>Help make a difference in women’s lives through a tax-deductible donation. NAMS is a 501(c)(3) nonprofit organization (tax ID 34-1604749).</td>
<td>$_______</td>
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</table>

Total  $_______

CVS/CW2 (security code found on credit card)

Signature

7/16
Please provide the following information, allowing NAMS to better serve the needs of its members.

Please complete the following:

1. Do you have a valid and unrestricted license for clinical practice?
   - Yes
   - No
   - Not applicable

2. Do you have a valid and unrestricted DEA Registration Number?
   - Yes
   - No
   - Not applicable

3. Have you ever been denied membership or reappointment to the medical staff of any hospital or have your privileges ever been suspended, curtailed, or revoked?
   - Yes
   - No
   - Not applicable

4. Have you ever been: (i) convicted of healthcare fraud or a healthcare-related crime; (ii) suspended, sanctioned, restricted, or excluded from participating in any private, federal, or state health insurance program; (iii) convicted of theft or embezzlement relating to a healthcare program; (iv) convicted of any crime in the course and scope of your professional employment?
   - Yes
   - No

5. Have any adverse circumstances occurred that prevent you from obtaining malpractice insurance?
   - Yes
   - No
   - Not applicable

6. Have you ever been convicted of a felony?
   - Yes
   - No
   - Not applicable

If you answered “No” to questions 1 or 2 or “Yes” to any of questions 3–6, please explain:

Name (please print)
Signature Date

Please indicate if you would like your name to be added to the NAMS Website “Find a Menopause Practitioner” list:
   - No, please do not include me in the list.
   - Yes, list me using the information on this application.
   - Yes, list me using the following contact information:

Mail to:
The North American Menopause Society
30050 Chagrin Blvd., Suite 120W
Pepper Pike, OH 44124
USA

Telephone 440/442-7550
Fax 440/442-2660
Email info@menopause.org
Website www.menopause.org