**SCSNM MEMBERSHIP RENEWAL/APPLICATION**

 **2019-2020**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **LAST FIRST MI DOB SEX**

**HOME ADDRESS­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_**

 **STREET CITY STATE ZIPCODE**

**EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*ANY CORRESPONDENCE (CEU Credits, etc.) WILL BE SENT TO THE ABOVE EMAIL ADDRESS\*\***

**List all**

**DEGREES/CREDENTIALS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_NEW APPLICATION \*FULL\_\_\_\_\_\_\_\_\_\_$40.00**

 **\_\_\_\_\_\_\_\_\_\_RENEWAL \*AFFILIATE\_\_\_\_\_\_\_\_\_\_\_$40.00**

**(PHARMACIST, PHARMACY TECHNICIANS, ETC.)**

**\*STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_$20.00**

 **(FULL TIME NUCLEAR MEDICINE STUDENT-14 MOS. MEMBERSHIP)**

**\*\*\*FIRST TIME APPLICANTS PLEASE FILL IN THE FOLLOWING INFORMATION\*\*\***

 **EDUCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **INSTITUTION DEGREE/CERTIFICATE**

 **REGISTRY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **REGISTRY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\*\*CHANGE OF ADDRESS/NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SIGNATURE DATE**

**PLEASE REMIT BEFORE SEP. 30, 2019 TO: David Taylor**

 **745 Leafy Bend Ct.**

 **Lexington, SC 29073**

**MAKE CHECKS PAYABLE TO: SCSNM**

**\*FULL MEMBER: FULL MEMBERS MUST BE A CERTIFIED AND/OR REGISTERED NUCLEAR MEDICINE TECHNOLOGIST. MEMBERS IN THIS CATEGORY WILL PAY DUES, HAVE VOTING PRIVILEGES, AND MAY HOLD EXECUTIVE OFFICE OR SERVE ON THE COUNCIL OF THE SCSNM.**

**\*AFFILIATE MEMBER: ASSOCIATE MEMBERSHIP IS RESERVED FOR THOSE INDIVIDUALS WHO ARE IN THE FIELD OF NUCLEAR MEDICINE BUT IS NOT A NUCLEAR MEDICINE TECHNOLOGIST. MEMBERS IN THIS CATEGORY WILL PAY DUES, HAVE VOTING PRIVILEGES, BUT MAY NOT HOLD EXECUTIVE OFFICE.**

**For Official Use Only: DATE RECEIVED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHECK NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_CARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RECEIPT\_\_\_\_\_\_\_\_\_\_\_\_\_\_MAILOUT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PayPal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**