

SCSNM MEMBERSHIP RENEWAL/APPLICATION – 2026-2027



NAME: _____
LAST FIRST MI DOB

HOME ADDRESS _____
STREET CITY STATE ZIP

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 EMAIL THE FORM TO: Gracynbrandon@gmail.com

OR MAIL TO: Gracyn Brandon
233 Westgate Drive
West Columbia, SC 29170

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 ARE 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 _____