



FLORIDA SLEEP MEDICINE SOCIETY

APPLICATION FOR MEMBERSHIP

Biographical Data

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Degrees/Certifications: _____ Gender: M F

I am currently a member of: AASM AAST AMA FMA

Contact Information *(Address must be within the state of Florida)*

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____ E-mail:* _____

This is my: Professional Address Home Address

**E-mail addresses will be used to provide members with information about FSMS news and events. The FSMS does NOT rent e-mail addresses to third-party organizations.*

Licensing/Certification Data *(please provide medical licensing and certification information from the state of Florida for the following degrees/certifications if applicable: MD, DO, DDS, RPSGT, RRT)*

Type: _____ License Number: _____ ^{Year of Initial} Licensing/Certification: _____ Expiration Year: _____

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Membership Classification *(please check the membership category for which you are applying)*

Membership is on a calendar-year basis (January 1–December 31). Dues for all membership categories in 2008 are \$50.

Physician Membership: Individuals possess an MD, DO, PhD, DDS, or other doctoral degree in sleep disorders medicine.

Technologist Membership: Individuals whose primary employment is the sleep technology profession.

Affiliate Membership: Individuals with special training in the healthcare field such as nurses and sleep center managers who are practicing or are interested in sleep medicine.

Method of Payment

Check made payable to the Florida Sleep Medicine Society (U.S. funds drawn on a U.S. bank) for \$50.

PLEASE SEND APPLICATION TO THE FSMS BUSINESS OFFICE LOCATED AT:

7029 SW 61 AVENUE
SOUTH MIAMI, FLORIDA 33143