SOCIETY OF INTERVENTIONAL PAIN MANAGEMENT SURGERY CENTERS
THE VOICE OF INTERVENTIONAL PAIN MANAGEMENT AMBULATORY SURGERY CENTERS

MEMBERSHIP CONTRIBUTION FORM

Please type or print your information clearly

SIPMS MEMBER Member ID _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

EMAIL _____

MEDICAL DIRECTOR _____

ADMINISTRATOR _____

❍ **Please update my contact information, the following is correct:**

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

EMAIL _____

MEDICAL DIRECTOR _____

ADMINISTRATOR _____

ANNUAL MEMBERSHIP FEES

- ❍ $2,500 1 to 2 Facilities
- ❍ $3,500 3 to 5 Facilities
- ❍ $5,000 6 to 9 Facilities
- ❍ $ 10,000 10 or more Facilities

CONTRIBUTIONS

- ❍ $25,000
- ❍ $20,000
- ❍ $15,000
- ❍ $10,000
- ❍ $5,000
- ❍ $2,000
- ❍ $1,000

PAYMENT

- ❍ I will mail a check, payable to SIPMS, with a copy of this completed form to: **SIPMS, 81 Lakeview Drive Paducah, KY 42001**
- ❍ I will fax or email this completed form with credit card information to: **crogers@asipp.org**

Method of Payment

❍CHECK (Enclosed, *Payable to SIPMS*) CHECK NUMBER _____

❍ MASTERCARD ❍ VISA ❍ AMERICAN EXPRESS ❍ DISCOVER

CREDIT CARD NUMBER _____ EXPIRATION DATE _____ SECURITY CODE _____

NAME AS IT APPEARS ON CARD _____

AUTHORIZED SIGNATURE *(required on all credit card orders)* _____