VASA Membership Form

Instructions

Please complete all sections of this application. Sign and return the application with payment to Vascular Access Society of the Americas, 446 East High Street, Suite 10, Lexington, KY 40507, or fax to (859) 271-0607 if paying by credit card.

CONTACT INFORMATION

First Name _____ Last Name _____

Home Address _____

City _____ State _____ ZIP _____

Business Name _____

Business Address _____

City _____ State _____ ZIP _____

Phone Number _____ Fax Number _____

Primary E-Mail Address _____

Password (for Website) _____

PROFESSIONAL INFORMATION

Major Clinical Practice Expertise:

- ☐ General Surgery
- ☐ Vascular Surgery
- ☐ Transplant Surgery
- ☐ Nephrology
- ☐ Interventional Nephrology
- ☐ Interventional Radiology
- ☐ Physician's Assistant
- ☐ Nurse
- ☐ Technician
- ☐ Dialysis Care Provider
- ☐ Corporate Professional

MEMBERSHIP FEES

☐ Physician Member: $225 ☐ Allied Health Member: $100

PAYMENT INFORMATION

Balance Due $ _____

☐ A check is enclosed (made payable to VASA).

☐ Please charge this amount to this credit card: $ _____

☐ AmEx ☐ Visa ☐ MasterCard ☐ Discover

Card Number _____

Expiration Date _____

Name on Card (please print) _____

Billing Address _____

Signature _____ Date _____

Send this form and payment to:

Vascular Access Society of the Americas
446 East High Street, Suite 10
Lexington, KY 40507
Fax: (859) 271-0607