



SOCIETY FOR PEDIATRIC ANESTHESIA

2209 Dickens Rd., Richmond, VA 23230-2005

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Last Name: _____ First Name: _____ MI: MD DO PhD CRNA Other

Preferred Mailing Address: _____

City: _____ State/Country: _____ Zip/Postal Code: _____

Office Phone: _____ Fax: _____ E-mail _____

Date of Birth (mm/dd/yy): ____/____/____ Type of Practice: Private University Government Other

Hospital Affiliation: _____

Academic Degrees & Other Professional Certifications With Dates: _____

ABA #: _____

I Hereby Make Application For:

- ACTIVE MEMBERSHIP:** \$175
Physicians practicing in the US or Canada who have an interest in pediatric anesthesia, and are eligible to be members of the ASA, may vote and/or hold office.
- AFFILIATE MEMBERSHIP:** \$175
Physicians not eligible to be members of the ASA, non-physicians with an interest in pediatric anesthesia. May not vote and/or hold office.
- ACTIVE/AFFILIATE JOINT MEMBERSHIP WITH CCAS:** \$200
Active and affiliate SPA members qualify for joint membership with the Congenital Cardiac Anesthesia Society.
 Active Joint Affiliate Joint
- INTERNATIONAL MEMBERSHIP:** \$50
Physicians practicing outside of the US and Canada who have an interest in pediatric anesthesia.
- INTERNATIONAL JOINT MEMBERSHIP WITH CCAS:** \$75
International SPA members qualify for joint membership with the Congenital Cardiac Anesthesia Society.
- RESIDENT/FELLOW MEMBERSHIP:** \$40
Physicians in an approved residency training program or performing post residency fellowship training (not to exceed five years). Resident membership requires endorsement by program director. Check if you are a fellow in pediatric anesthesia.

Residency Location: _____

Completion Date: _____ Signature of Program Director: _____

Referred by: _____

Payment Options:

Check or Money Order Enclosed (US Funds) Made Payable to: SPA, 2209 Dickens Rd., Richmond, VA 23230-2005.

AmEx Mastercard Visa Discover Card Number: _____

Expiration Date: _____ Printed Name on Card: _____

Signature: _____ Date: _____