AMERICAN SOCIETY OF MULTICULTURAL HEALTH AND TRANSPLANT PROFESSIONALS
MEMBERSHIP APPLICATION

Date: _____ ☐ New Application ☐ Renewal Application ☐ Update New Information

TYPE OF MEMBERSHIP: ☐ Active Individual $125.00 ☐ Corporate Sponsor $1,000 and up ☐ Corporate Associate $200.00 ☐ Friend $60.00

PERSONAL: (Print or type clearly)
First Name, Middle Initial, Last Name: _____

Job Title: _____

Institution Name: _____

Department: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Office_____ FAX_____ email_____

EDUCATIONAL LEVEL:

☐ HS Diploma ☐ AA ☐ PA ☐ Diploma RN ☐ BA ☐ BS
☐ BSN ☐ MSN ☐ MA ☐ MS ☐ MSW ☐ MBA
☐ MPA ☐ MPH ☐ Ph.D. ☐ Ed.D. ☐ JD
☐ Other _____

CERTIFICATION/LICENSURE:

☐ LPN/LVN ☐ RN ☐ CCRN ☐ NP ☐ PA ☐ CPTC ☐ CCTC
☐ EMT/Paramedic ☐ MD ☐ Pharm. D. ☐ LCSW ☐ Other _____

EMPLOYER:

☐ Community Hosp. ☐ Univ. Med. Ctr. ☐ Private Foundation ☐ Blood Bank
☐ Physician's Office ☐ Military/VA Hosp. ☐ Tissue Bank ☐ Eye Bank
☐ Hosp based OPO ☐ Independent OPO ☐ Other _____

PRACTICE:

☐ Intensive Care ☐ General Unit ☐ Transplant Unit ☐ Operating Room
☐ Pediatrics ☐ Clinical Outpatient ☐ Organ Procurement ☐ Tissue procurement
☐ Preservation ☐ Histocompatibility ☐ Administration ☐ Professional Education
☐ Clergy Education ☐ Public Education ☐ Outreach/Volunteer ☐ Hosp. Development
☐ Requestor ☐ Public Relations ☐ Organ Placement ☐ Dialysis Center/Unit
☐ Other _____

Make check or money order payable to ASMHTP and send with application to:
ASMHTP Membership
UNOS 700 N. 4th St.
Richmond, VA 23219
Toll free: 1-866-ASMHTP-1 FAX 1-804-782-4816

email: ASMHTP@asmhtp.org

!!!!!!!! MEMBERSHIP EXPIRES DECEMBER 31ST OF EACH CALENDAR YEAR !!!!!!!

For Office Use:

Date received_____ Check # _____ ☐ Personal Check ☐ Employer Check ☐ Other _____