



American Society of Multicultural Health and Transplant Professionals (ASMHTP)

Renewal Individual Membership

Date: _____

Active Individual (\$125)*
(* only \$112 with Organizational Membership!)

Friend (\$60)

PERSONAL INFORMATION

Name: _____	
Organization Name: _____	
Title: _____	Department: _____
Address: _____	
City: _____	State: _____ Zip: _____
Phone: _____	Email: _____

► Please fill out the section below **ONLY** if you have any changes to report from last year. Thank you!

EDUCATION LEVEL:

- | | | | | | |
|-------------------------------------|------------------------------|--------------------------------|-------------------------------------|------------------------------|---------------------------------------|
| <input type="checkbox"/> HS Diploma | <input type="checkbox"/> AA | <input type="checkbox"/> PA | <input type="checkbox"/> Diploma RN | <input type="checkbox"/> BA | <input type="checkbox"/> BS |
| <input type="checkbox"/> BSN | <input type="checkbox"/> MSN | <input type="checkbox"/> MA | <input type="checkbox"/> MS | <input type="checkbox"/> MSW | <input type="checkbox"/> MBA |
| <input type="checkbox"/> MPA | <input type="checkbox"/> MPH | <input type="checkbox"/> Ph.D. | <input type="checkbox"/> Ed.D. | <input type="checkbox"/> JD | <input type="checkbox"/> Other: _____ |

CERTIFICATION/LICENSURE:

- | | | | | | | |
|--|-----------------------------|-----------------------------------|-------------------------------|---------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> LPN/LVN | <input type="checkbox"/> RN | <input type="checkbox"/> CCRN | <input type="checkbox"/> NP | <input type="checkbox"/> PA | <input type="checkbox"/> CPTC | <input type="checkbox"/> CCTC |
| <input type="checkbox"/> EMT/Paramedic | <input type="checkbox"/> MD | <input type="checkbox"/> Pharm. D | <input type="checkbox"/> LCSW | <input type="checkbox"/> Other: | | |

EMPLOYER:

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Community Hospital | <input type="checkbox"/> University Medical Center | <input type="checkbox"/> Private Foundation | <input type="checkbox"/> Blood Bank |
| <input type="checkbox"/> Physician's Office | <input type="checkbox"/> Military/VA Hospital | <input type="checkbox"/> Tissue Bank | <input type="checkbox"/> Eye Bank |
| <input type="checkbox"/> Hospital Based OPO | <input type="checkbox"/> Independent OPO | <input type="checkbox"/> Pharmaceutical | <input type="checkbox"/> Other: _____ |

PRACTICE:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Intensive Care | <input type="checkbox"/> General Unit | <input type="checkbox"/> Transplant Unit | <input type="checkbox"/> Operating Room |
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Clinical Outpatient | <input type="checkbox"/> Organ Procurement | <input type="checkbox"/> Tissue Procurement |
| <input type="checkbox"/> Preservation | <input type="checkbox"/> Histocompatibility | <input type="checkbox"/> Administration | <input type="checkbox"/> Professional Education |
| <input type="checkbox"/> Clergy Education | <input type="checkbox"/> Public Education | <input type="checkbox"/> Outreach/Volunteers | <input type="checkbox"/> Hospital Development |
| <input type="checkbox"/> Requestor/Family Services | <input type="checkbox"/> Public Relations | <input type="checkbox"/> Organ Placement | <input type="checkbox"/> Dialysis Center/Unit |
| <input type="checkbox"/> Other: _____ | | | |

Make check or money order payable to ASMHTP and send with membership form to:
 ASMHTP Membership, UNOS 700 N. 4th Street, Richmond, VA 23219 • Toll free: 866-ASMHTP-1 Fax: 804-782-4816
 email: asmhtp@asmhtp.org Web site: www.asmhtp.org

(Annual membership expires on December 31st of each calendar year—remember to renew!)

Date Received: _____	Check #: _____	For Office Use:
		<input type="checkbox"/> Personal Check <input type="checkbox"/> Employer Check <input type="checkbox"/> Other _____