

AECD

ASSOCIATION OF ENDOCRINE CHIEFS AND DIRECTORS



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2016 APPLICATION FOR MEMBERSHIP

NAME (PLEASE PRINT CLEARLY)			
First (Given):	Middle:	Last (Surname):	
MAILING ADDRESS			
Institution:	Department:		
Street/PO:			
City:	State:	Zip/Mail Code:	Country:
Telephone:	Fax:	Email Address:	
PROFESSIONAL INFORMATION			
Degrees:	Professional Title:		
SECTION 1. DUES			
<input type="checkbox"/> \$300 per year (expires Dec. 31 annually) <input type="checkbox"/> \$150 (July 1 – Dec. 31, 2016)			
SECTION 2. PAYMENT (Please submit payment with application and CV/NIH biosketch)			
Payment:			
1. CHECK. Please make checks payable to Endocrine Society in U.S. funds only, drawn on a bank with a U.S. branch, or complete the credit card information below. Mail checks to: Endocrine Society, PO Box 17020, Baltimore, MD 21297-1020			
2. CREDIT CARD: <input type="checkbox"/> American Express <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa			
Mail credit card form to: Endocrine Society, attn: AECD, 2055 L Street, NW, Suite 600, Washington, DC 20036 OR Fax form to: +1.202.736.9704			
Card Number:		Expiration Date:	
Name of Cardholder (please print):			
Billing Address (if different than mailing address above):			
Signature			
Your signature authorizes your credit card to be charged for the Dues. The Endocrine Society reserves the right to charge the correct amount if different from the Dues.			
SECTION 3. ADDITIONAL CONTACT			
If you like, you may name one additional contact for your program (e.g. an assistant). This person will not have full membership access and benefits, but will be included in all communications.			
Name: _____ Position: _____ Email: _____			
FOR OFFICE USE ONLY			
Accepted By:	Member ID:	Join Date:	